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91st Congress }
1st Session }

COMMITTEE PRINT

MEDICARE AND MEDICAID

PROBLEMS, ISSUES, AND ALTERNATIVES

REPORT OF THE STAFF
TO THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*



FEBRUARY 9, 1970

Printed for the use of the Committee on Finance

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(II)

LETTER OF SUBMITTAL

FEBRUARY 3, 1970.

HON. RUSSELL B. LONG,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. CHAIRMAN: Attached herewith is the report of the staff on "Medicare and Medicaid—Problems, Issues, and Alternatives." The report was prepared in compliance with the committee's direction of February 26, 1969, that the staff undertake an inquiry into the status and operations of the medicare and medicaid programs.

During the staff's investigation and development of material, as well as in preparation of the report itself, we were mindful of the fact that medicare has provided invaluable and necessary aid to millions of older Americans. Consistent with that viewpoint, the recommendations we have included in the report are designed to repair rather than retrench. Medicare is a good Federal program. However, as the report illustrates, the staff review indicates major areas in which constructive changes, either in the statute itself or in the administration of the program, can prepare medicare to meet the needs of the Nation's elderly on a vastly more efficient and economical basis while improving the quality of care rendered under the program.

While the medicaid program has helped millions of poor citizens with their health care needs, it has not nearly approached the congressional objectives of assuring good health care for the poor in an effective and economical fashion.

One significant source of data and information used in the work on this report was the response to questionnaires prepared by the staff and circulated widely among groups and individuals closely associated with the medicare and medicaid programs. These questionnaires were mailed to the Governor of every State, to every medicare intermediary and carrier, to every State hospital association, and to every State medical society as well as to every major national organization concerned with medicare and medicaid. The response to these questionnaires was tremendous, the information we received from the replies was most helpful, and as the report demonstrates, many of the replies were unusually candid.

Another indication of the depth of the study is the large number of meetings and conferences held with individuals and groups close to the program. These, too, proved quite valuable in our quest for information.

In the actual preparation of the report we received important and extensive assistance from the Comptroller-General of the United States and his staff. Particularly, the staff benefited greatly from the valuable expert and detailed assistance provided by the Education and Public Welfare Division of the Legislative Reference Service in

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the Library of Congress. Additionally, the Bureau of Health Insurance of the Social Security Administration was helpful and cooperative in obtaining and preparing information and otherwise providing assistance pursuant to our many requests.

Sincerely,

TOM VAIL,
Chief Counsel, Committee on Finance.

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INTRODUCTION

The medicare and medicaid programs are in serious financial trouble. The two programs are also adversely affecting health care costs and financing for the general population.

Medicare began providing benefits on July 1, 1966. Its financing had been established on what Congress believed to be conservative and safe bases. Yet, little more than 1 year after the program started, Congress found it necessary to increase medicare taxes by some 25 percent in order to meet hospital cost increases beyond those originally anticipated.

The President submitted to the Congress, in September 1969, a proposal calling for an additional \$136 billion in medicare payroll taxes over the next 25 years. The \$136 billion is in addition to prospective increases in medicare taxes already scheduled in the Social Security Act. Of the \$136 billion, \$131 billion represents the amount by which medicare's expenditures are expected to exceed its anticipated income and the remaining \$5 billion is a safety factor. Without those additional taxes, the Social Security Administration estimates that the hospital insurance trust fund will be exhausted by 1973.

When medicare started on July 1, 1966, the medicare beneficiary was responsible for paying at least the first \$40 of his hospital bills in accordance with the deductible and copayment requirements of the law. On January 1, 1969, the deductible was increased to \$44 and effective on January 1 of this year it was raised to \$52. According to Social Security's Chief Actuary, the deductible will very likely jump to \$60 in 1971; \$68 in 1972; \$76 in 1973; and to \$84 on January 1, 1974.

The part B portion of medicare—the supplementary medical insurance plan for payment of doctors' bills—has also soared in cost. The monthly premium charge to the elderly is now \$4—up from \$3 monthly when medicare began on July 1, 1966. Under the law, the monthly premiums paid by the elderly are matched with an equal amount from the general revenues of the Federal treasury.

In December 1969, the Secretary of Health, Education, and Welfare announced that the part B premium would be increased to \$5.30 monthly effective July 1, 1970. That increase amounts to \$600 million annually of which \$300 million will represent increased Federal expenditures and \$300 million will come from the pockets of 20 million older citizens.

Under present law, the institutional suppliers of covered health services under medicare (and medicaid, in large part, also) are paid whatever it costs them to provide the services. Physician bills under medicare are essentially paid as rendered. Unlike most areas in the private economy no incentives exist to produce or supply a given health service at the most economical price consistent with quality of care. To the contrary, hospitals and extended care facilities can, under present medicare and medicaid reimbursement rules, spend money on virtually anything and be paid for it by Government.

Unless the rapid and continuing escalation in the costs of health care are moderated, the Congress may reasonably anticipate increasing pressures upon it to extend the medicare and medicaid programs to encompass large segments of the population not now covered under these public health payment plans.

Those pressures for expansion and extension will come from citizens with moderate incomes who are now covered by Blue Cross-Blue Shield and other private health insurers. People are being priced out of the private health insurance market as a result of the frequent and substantial premium increases required to meet the ever-greater costs of health care.

The charges for adequate nongovernmental health insurance are rising to levels beyond the financial capacity of millions of hardworking Americans. Most of those people probably would prefer to continue their private coverage rather than become part of a monolithic system of governmental health care. Under present and foreseeable conditions, however, whatever choice they now have in the matter may be removed by circumstances beyond their control.

The working man today is confronted with:

- a. Social security tax increases to pay for medicare.
- b. Increases in his private health insurance premiums.
- c. Increased State and local taxes to pay for medicaid.
- d. More of his Federal tax dollar going to the Federal share of medicaid and medicare costs.
- e. More out-of-pocket costs to cover his coinsurance portion of higher and higher medical charges.
- f. More out-of-pocket costs for rapidly rising charges for largely noninsured health services such as dental care.

To simply expand the medicare and medicaid programs as now constituted and operated would, we believe, compound costs and confusion. That would not solve the problems of increasing costs—rather it would add to them. Eventually, under such conditions, the individual would have traded higher insurance premiums for even higher taxes, and there would be little private health insurance as we know it today available to our people.

With a view toward improving the medicare and medicaid programs the staff has included suggestions and recommendations which we believe provide bases for remedying the serious, costly, and pervasive problems we have found. We believe these suggestions can make medicare and medicaid work more efficiently and economically.

The key to making the present system workable and acceptable is the physician and his medical society. We are persuaded that at this point in time neither the Government nor its agents have the capacity for effective audit to assure that a given physician functions responsibly in dealing with the publicly financed programs.

While there is growing awareness among many physicians of the need for the profession to effectively police and discipline itself, performance has been spotty and isolated so far. Prompt action is necessary by organized medicine (and other health care professions) to do what is required with respect to monitoring care provided and charges made for the care. In the absence of such constructive effort, we fear that virtually insurmountable pressures will develop for alternative control procedures which may be arbitrary, rigid and insensitive to the legitimate needs of both the patient and his physician.

SUMMARY

See pages

The staff in its review of the status and operations of the medicare and medicaid programs focused upon the principal problem areas. Our findings and suggestions for improvement are summarized following a brief discussion below of the fiscal impact of the medicare and medicaid programs.

1. Fiscal Impact of Medicare

Hospital Insurance Plan (Part A):

In 1965 when medicare was enacted, the insurance program for payment of hospital bills was estimated to cost 1.23 percent of taxable payroll. (Taxable payroll is the total of all earnings subject to social security taxes.) Consistent with the express intent of the Congress that medicare estimates be conservatively made, it was specifically assumed that the maximum individual wages subject to medicare tax would remain at \$6,600 annually during the life of the 25-year cost estimate.

29-37

After only 3 years of experience, the conservative assumptions have been abandoned due to soaring costs resulting from price increases and greater-than-anticipated utilization of covered services. Currently, medicare's hospital plan is estimated to cost 2.27 percent of taxable payroll based upon \$7,800 of individual annual wages subject to the hospital tax.

Boiled down to dollars, as the following table reveals, the estimated cost for calendar year 1970 has jumped from the original projection of \$3.1 billion to a current estimate of \$5.8 billion. And, from 1970 onward, the yearly gap between original estimates of costs and current projections progressively widens by billions of dollars.

HOSPITAL INSURANCE BENEFIT COST PROJECTIONS

[In billions of dollars]

	Estimate of 1970 costs	Estimate of 1975 costs	Estimate of 1990 costs
Actuarial estimate made in 1965.....	3.1	4.3	8.8
Actuarial estimate made in 1967.....	4.4	5.8	10.8
Actuarial estimate made in January 1969.....	5.0	7.6	16.8
Current estimate.....	5.8	(1)	(1)

¹ Not available.

See pages

As was noted in the introduction, the estimated deficit between the costs of part A of medicare and projected income under present law amounts to \$131 billion over the next 25 years. The hospital insurance trust fund will be exhausted in 1973 under present financing.

The President has requested, and Congress will consider imposing, additional taxes necessary to finance the \$131 billion shortfall. In all of this, it is obvious that the repeated and enormous demand for new taxes to pay for existing levels of medicare benefits serves to preempt payroll tax potential which might otherwise be available for program improvement. The staff points out that legislative alternatives are reduced when Congress is forced to increase medicare taxes simply to keep the existing program above water.

Supplementary Medical Insurance Plan (Part B):

37-39

When medicare began on July 1, 1966, the insured beneficiary paid a monthly premium of \$3 with an equal amount paid by the Federal Government from general revenues (total monthly premium of \$6 per person), toward coverage of his doctor bills.

The costs of part B have soared. The original \$3 monthly premium was increased to \$4 on July 1, 1968, and is scheduled to jump again to \$5.30 monthly on July 1, 1970.

In the simplest of terms, the Federal share of part B costs will have increased from \$623 million in fiscal year 1967 to an estimated \$1,245 million in fiscal year 1971. (The insured elderly will match that \$1,245 million from their own resources.)

2. Fiscal Impact of Medicaid

41-44

The budgetary impact upon State, local and Federal Governments of expanded eligibility and benefits coupled with increases in unit costs of medical assistance under the various welfare programs has been enormous.

In fiscal year 1965 total Federal-State medical assistance expenditures amounted to \$1.3 billion of which the Federal share was \$555 million. For fiscal year 1970, the Department of Health, Education, and Welfare estimates total expenditures of \$5.5 billion (including the costs of intermediate care facilities) of which the Federal share is \$2.8 billion. Based upon the above figures, Federal expenditures for medical assistance will have increased five-fold from fiscal year 1965 through fiscal year 1970 with commensurate increases in expenditures by State and local governments.

3. Reimbursement of Institutions Providing Medical Care

45-46

Comprehensive assessment of the financial position of hospitals in light of medicare reimbursement must await more complete data than are available in usable form now—even though more than 3½ years have elapsed since the

program started. There is, however, consensus concerning a need for ultimate revisions—liberalizing and restricting—in both reimbursement procedures and the formula itself. *See pages*

Making "Reasonable Cost" More Reasonable

The basic direction in any changes will presumably be toward more equitable reimbursement—from the standpoint of both Government and health care providers—coupled with simplified and coordinated cost reporting requirements. *46-50*

Where a given institution demonstrates that it incurs greater than ordinary costs in caring for medicare patients, those additional costs should be reimbursable provided they are not unreasonable. However, blanket recognition of increased nursing and clerical time should be avoided. It appears illogical, for example, to pay a plus factor for increased nursing time to institutions which do not fully meet the conditions for medicare participation, particularly those with staffing deficiencies.

Cost finding and auditing have proved to be highly expensive undertakings in medicare as well as a source of much friction. The legislative history indicates a concern that proper accounting be required not only for proper determination of payment but also as desirable adjuncts of good management. However, Congress did not intend accounting and audit "overkill" in pursuit of those objectives. The Bureau of Health Insurance should be encouraged in its efforts to revise procedures so as to avoid requiring what in essence amounts to duplicate cost finding on the part of hospitals. Additionally, less extensive and simpler costs data might be required of smaller institutions.

There have been inordinate and protracted delays in final settlement of accounts for specific calendar years—delays of years in many instances. To encourage prompt settlement, it is recommended that the Government pay interest on any amounts due to an institution where unreasonable delay in settlement is the responsibility of the Government. Similarly, interest should be charged on amounts due the Government where unusual delay in settlement is caused by the participating facility.

Cost-plus reimbursement was dropped from medicare effective July 1, 1969. That policy encouraged duplication, overlapping, and unnecessary expansion of facilities and services and created an unhealthy economic incentive to maximize operating costs. The pursuit of equitable reimbursement is not served, in our opinion, by any cost-plus method of payment except where the "plus" factor is related on an incentive basis to economical performance.

The 2-percent bonus in medicare had been rationalized as a growth factor by hospital organizations. Perhaps the Federal Government would want to expand its efforts to meet the capital needs of hospitals which cannot otherwise be met through depreciation, contributions, regular borrowings, and so forth. If it should, we suggest that it be done by direct appropriations for that purpose and not financed

See pages through devices in the medicare reimbursement formula. In our judgment, medicare was enacted for a wholly different purpose. Any significant capital improvement financed in whole or part by the Federal Government should be contingent upon approval of an appropriate and technically qualified community or State planning agency broadly representative of all of the various types of health care and services. The planning body should not be directly or indirectly controlled or dominated by hospitals. Capital expenditures should be approved only after thorough consideration has been given to existing and alternative health care resources already available or approved in a given community or medical service area. Simply stated, the capital expenditure should be necessary in the context of priorities for meeting overall community needs.

Where approved capital needs cannot otherwise be met, the existing reimbursement formula might be modified to allow the expenditure to be depreciated in one-half the time ordinarily accepted but only where the expenditure had been approved as expected to substantially contribute to efficiency.

As indicated in the report, the entire reimbursement formula and procedures for medicare need careful review and substantial revision. In the staff's opinion the existing formula and its implementation have undoubtedly contributed significantly to the unanticipated rise in part A costs, and to the \$131 billion projected 25-year deficit in medicare.

Legislation presently before the committee, S. 1195, provides bases for moderating the extent of this anticipated "shortfall." The proposal would preclude reimbursement to the extent that a hospital's increase in average per diem operating costs over the previous year rose at a rate greater than the Medical Care Price Index for that particular geographic or metropolitan area. The Secretary of Health, Education, and Welfare could, under unusual and justifiable circumstances, authorize payments in excess of the limitation. However, medicare could not pay under cost reimbursement more to an institution than its charges for the same services to the general public. No reimbursement could be made for capital costs associated with an expenditure specifically disapproved by a State's "partnership for health" agency. The staff urges serious consideration of the provisions of this bill.

In addition, the staff suggests that payment for care provided in one institution be limited to not more than a reasonable difference above costs for comparable care and services in a similar, less expensive, institution in the same area.

Reimbursement of Hospital "Reasonable Costs" Under Medicaid

50-51 The statutory requirement that States pay hospitals on the basis of "reasonable costs" under medicaid has been interpreted by the Department of Health, Education, and

Welfare to mean payment identical with that of medicare. *See pages* That interpretation has been costly to the States and has hampered their efforts to control costs. The staff believes that Congress intended, as with many other welfare requirements, that States be permitted to define "reasonable costs" within general guidelines issued by the Secretary of Health, Education, and Welfare. The medicare pattern could fall within those guidelines but States should not be restricted to the medicare formula or even to the medicare pattern. This understanding seems reasonable in view of the difference between medicaid and medicare, and in terms of the ages of the populations assisted, sources of financing, and primary administrative responsibility. The staff recommends that congressional intent be clearly established with respect to the relationship between reimbursement under medicare and medicaid.

Other Issues in Institutional Reimbursement

Among specific additional problems in institutional cost reimbursement are: *52-53*

Payment for empty beds costs.—Under present regulations it is possible for a new hospital or extended care facility (or even older facilities) to be paid for such costs to an unreasonable degree. For example, an extended care facility in Wisconsin with patient capacity of 25 beds had no more than three beds occupied at any given time, with medicare patients accounting for the limited occupancy. As a result, an average cost per diem of \$87 was claimed from medicare.

To deal with such situations, the staff suggests payment of the lesser of costs or the published charges ordinarily payable by a nonmedicare patient and limiting medicare's empty beds reimbursement to a proportion based upon average actual medicare occupancy in relation to the total number of beds available.

Bad debt collection.—Information has been developed indicating that some hospitals and extended care facilities make only perfunctory efforts to collect the deductible and copayment sums due from beneficiaries toward the costs of their care. Those unpaid amounts are then charged-off as a reimbursable "bad debts" expense under medicare. The result is that medicare bears the entire cost of care, thus thwarting the purpose of the deductible and copay features in the medicare statute. With the present \$52 deductible expected to rise to \$84 by 1974, with accompanying commensurate increases in other part A copayment requirements, it is important that all participating institutions make a genuine effort to collect from beneficiaries before passing those amounts on to medicare as uncollectible.

Reimbursement for bad debts attributable to nonmedicare patients is not allowable under medicare. Yet, Social Security, despite concern expressed by the General Accounting Office, has authorized payment of a proportionate share of collection costs of nonmedicare bad debts. Such collection is often undertaken by independent collection agencies in

See pages return for a specified percentage of amounts collected. Where such collection costs are recognized, medicare, in effect, is paying for nonmedicare bad debts. The staff recommends termination of such payments by medicare.

*The liberal depreciation allowances payable under medicare—*including accelerated depreciation—may well be causing the sale and resale of proprietary facilities at inflated prices. The objective in such situations would be to repeat the writeoff of the facility and its equipment through accelerated depreciation and thereby realize inordinately high and duplicative cash payments from the Government.

This situation is also conducive to transformation of for-profit facilities into nonprofit institutions with the owners selling to a pro forma nonprofit organization at a high price with the purchase price payable on an installment basis from the excess of revenues over expenses of the now "tax free" institution.

The staff suggests issuance of regulations (and assurance of their enforcement) providing for tightened appraisal procedures where facilities change hands. In such appraisals "goodwill" should not be recognized as an element of cost, and depreciation should be allowable only on a straight line basis as is the case under the tax laws.

4. Tax-Exempt Status of Community Hospitals and Obligation To Provide Charitable Care

55-58

The staff again calls the committee's attention to a recent ruling by the Internal Revenue Service (Revenue Ruling 69-545) which overturns prior Service policy that a hospital must provide charitable services to the extent of its financial ability in order to justify tax exemption. The new ruling was announced on October 8, 1969, after the House passed H.R. 13270, the tax reform bill, which included a provision similar in purpose to the ruling, but before the Finance Committee deleted the House amendment. The Senate's action in removing the provision was accepted by the House. The Finance Committee in deleting the amendment noted that it desired to consider the question later in the context of medicare and medicaid.

If the Service, despite the recent legislative history, retains the policy enunciated in the new ruling, it is conceivable that:

1. Many marginal income families, not now eligible for help with hospital bills under either medicare or medicaid and whose resources are insufficient to pay for necessary care might be denied hospital care now available to them. This is especially true in the many States which do not now pay for hospital care provided to welfare recipients of general assistance. In turn, this would place greater pressure upon States and Congress to expand medicaid at the very time Congress is seeking means of contracting and moderating the program.

2. To the extent hospitals insist that medicare and medicaid did not pay their full costs they might contend that they were being asked to provide free or below-cost care. Those hospitals, perhaps might refuse to serve or limit service to medicare and medicaid patients, unless the Federal and State Governments met their unilateral cost determinations and demands. Without the balancing effect of the requirement that free and below-cost care be provided, Government might be faced with the choice of complying with payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals to which contributions may be made on a tax-deductible basis.

See pages

It is also a matter of fact that the extent of free and below-cost hospital care has diminished greatly since the advent of public programs such as medicare and medicaid.

The staff strongly recommends revocation of Revenue Ruling 69-545 and continuation of the prior position of the Service. Such action by the Service would assist in protecting the availability of necessary hospital care to medicare, medicaid, and other poor patients.

5. Payment for Physicians' Services

The provisions of the statute and the clear congressional intent that medicare carriers should not pay physicians more than they would ordinarily pay for their own subscribers has not been followed. Congress said that in paying physicians "consideration" should be given to customary and prevailing fees. In actual practice the medicare regulations require that payment should be made solely on the basis of customary and prevailing fees and that private insurance schedules should not have any influence on what medicare paid. As a consequence, medicare generally allows payments for the aged which are substantially higher than those paid under Blue Shield's most widely held contracts for the working population, and thus physicians' incomes have been inflated.

59-67

The failure to maintain detailed data with respect to customary charges for each physician and for prevailing fees in each locality has led to weak administrative practices, unwarranted delays in payments to physicians and beneficiaries, and high administrative costs. No doubt medicare's pattern of inflated payments has also served to increase physicians' charges to the general public because a doctor is not permitted to charge more under medicare (at least theoretically) than he does for his other patients.

There is evidence that many physicians are resorting to "gang visits" and unnecessarily frequent visits to nursing home and hospital patients in order to up their medicare payments. Under this practice a physician may see as many as 30, 40, and 50 patients in a day in the same facility—regardless of whether the visit is medically necessary or whether any service is actually furnished. The physician in many cases charges his full fee for each patient, billing

See page medicare for as much as \$300 or \$400 for one sweep through a nursing home.

In addition, it appears that many physicians are now billing separately for services which were previously routinely included in a charge for an office visit or a surgical fee. For example, routine laboratory tests which were part of the office visit charge are now billed in addition to the fee for the visit. In some cases a surgeon now charges separately for preoperative and postoperative visits, services which used to be included in his surgical fee.

The results of the above deficiencies, abuses, and lack-luster administration are reflected in rapidly rising premium charges for part B. In the opinion of the staff unless basic changes are made in the structure of reimbursement for physicians' services, substantial additional premium increases can reasonably be anticipated.

The staff believes that the existing interpretation of the part B statutory limitation is erroneous and not consistent with the congressional intent. We recognize, however, that the interpretation has been applied for more than 3 years; thus the first suggestion offered below is intended as a stop-gap measure. As a permanent solution we think the provisions concerning reimbursement of physicians should be rewritten in the statutes. With that thought in mind, the staff has developed a basis for comprehensive revision which is outlined in the second recommendation below.

Recommendation for Reasonable Limit on "Reasonable Charges"

67 To conform present medicare practice to the congressional intent expressed in the statute and contemporaneous committee reports and if no substantive changes are made in part B the staff recommends that all Blue Shield plans serving as medicare carriers be required to limit the physician's charge recognized as "reasonable" to not more than the average payment actually made for a given service or procedure under all of its basic surgical-medical subscriber contracts during a reasonably recent prior period of time. Thus, for example, if Blue Shield in Massachusetts under all of its various subscriber contracts actually paid an average of \$250 for removal of cataract (excision of lens) during 1968, medicare would not recognize charges above \$250 as "reasonable" for purposes of reimbursement.

For those services which medicare covers but which Blue Shield does not, maximum allowances could be calculated on a basis relative to the average actual payments which Blue Shield made on the services it does cover.

Additionally, to avoid, at least to some extent, costly and often medically unnecessary "gang visiting," amounts allowed should be reduced for multiple visits, on the same day to patients in the same facility. Similarly, limitations on amounts allowed for "injections" and routine laboratory tests should be established and applied.

Fee Schedules: Recommendation for a Part B Program With Built-In Cost Limitations *See pages 67-69*

We have developed a basis for possible revision of part B of medicare, in large part based upon customary insurance practices in the private sector, which the committee might consider as a mechanism to substantially simplify administration and control costs.

1. An advisory board of actuaries and underwriters would be selected by the Secretary of Health, Education, and Welfare from private health insurance companies to assist in developing a schedule of fixed indemnity allowances for surgical and medical care for each of the nine census regions in the Nation (in recognition of geographic variation in charges for similar medical services). The allowances for any given region should not be more than 10 (or possibly 15) percent greater than the average for all other census regions combined. Appropriate provision should also be made so that prepaid group practice and similar programs can provide care and be reimbursed on other than a fee-for-service basis.

2. The advisers would recommend specific maximum amounts allowable for covered services based upon a total monthly premium of \$8 per beneficiary—the amount now paid—after allocating a sufficient portion of the premium for reserves and administrative costs.

3. The \$50 deductible now in part B would apply only to charges for services rendered by nonparticipating physicians.

4. Payments would be made on the basis of 80 percent of the maximum amount allowable specified in the benefits schedule or 80 percent of the actual charge, whichever was less.

5. A participating physician would be one who agrees to accept the scheduled allowance as his full charge for the services he renders to all medicare beneficiaries. In the case of a participating physician payments would be made directly to him by medicare. He would collect 20 percent of the scheduled amount from the beneficiary. Alternatively, a co-pay approach might be employed. For example, the beneficiary would pay out of pocket the first \$2 or \$3 of the charge for home and office visits.

6. Where a doctor did not elect to become a participating physician all payments due from medicare to beneficiaries for services rendered by him would be made directly to those beneficiaries on the basis of a receipted or nonreceipted bill.

7. A physician could, upon appropriate notice, elect, or withdraw from, status as a participating physician.

8. The \$8 monthly premium rate would be fixed by law and could not be changed except by legislative action.

9. In case the premium and reserves were inadequate to fully meet the obligations of the program in a given year, the advisory board would be expected to adjust the scheduled allowances downward so as to make up the deficit in the following year or years. Such revisions could be made ap-

See pages applicable only to those regions experiencing abnormal utilization or could be made applicable nationally.

Recommendation for Uniform Definitions of Medical Procedures

69 To avoid fragmentation of fees the staff recommends that uniform definitions of medical procedures and services be applied in the payment of benefits under part B.

Adoption of uniform definitions would avoid situations such as that where a surgeon charges one fee for the actual surgery and then charges additional separate fees for normal preoperative and postoperative visits. Most Blue Shield plans allow a single inclusive fee covering the preoperative and postoperative care ordinarily and routinely provided in conjunction with the surgery itself.

Appropriate definitions can be obtained from Blue Shield and others.

6. Payments to "Supervisory" Physicians in Teaching Hospitals

71-79 A major and costly problem has arisen in medicare with respect to payment for the services of so-called "supervisory" physicians in teaching hospitals. Such services may involve medicare payments of \$100 million or more annually.

The problem concerns charges to "institutional" (also called "service") patients in contrast to bona fide private patients.

The institutional patient generally does not have a private physician in the normal sense.

Private patients on the other hand generally have their own doctors who visit and treat them during the hospital stay. The private patient has chosen and in effect, contracted with his doctor, whereas the institutional patient—without a private doctor of his own—has an attending physician assigned to him by the hospital. The service patient, thus, looks to the institution for his medical care rather than to a private physician.

Serious questions have arisen with respect to payments to supervisory physicians designated as attending physicians for medicare beneficiaries—including possible fraudulent submission of claims for services never rendered.

What has occurred is that medicare offered teaching institutions and physician associations an opportunity to secure funds through billing the institutional patient as if he were a private patient. The teaching physicians, themselves, do not appear to be profiting personally from the billing to medicare of private patient fees for institutional patients.

The services to institutional patients are often actually provided by interns and residents and are paid for under the hospital insurance plan. Medicare may be paying for the same service twice when it also pays the "supervisory" physician under the medical insurance plan.

Prior to medicare, few Blue Shield plans or commercial health insurers paid on a fee-for-service basis for supervisory

services rendered by teaching physicians in teaching hospitals. Relatively few teaching institutions even attempted to bill for such services—it was not “customary” nor did it “prevail.” *See pages*

The basis for reimbursement of supervisory physicians under medicare was established by the Bureau of Health Insurance upon recommendations of an advisory group it appointed whose membership consisted solely of those who might benefit from those recommendations.

The staff questions whether the medicare beneficiary is under any legal obligation to pay for such services and, as noted, found little precedent prior to medicare for submission of charges for “supervisory” physicians.

We believe the practice is wrong and must be stopped. While medical schools and teaching hospitals are undoubtedly in need of additional sources of funds, the staff does not believe that millions of older people should be required to subsidize medical education through their part B premiums. The proper approach to additional financing of medical education is through the appropriations process where needs can be established, justified, and met on the basis of specific requirements of specific institutions.

7. Large Payments to Health Care Practitioners

The Appropriations Committee of the Senate annually secures and publishes a listing of those to whom payments aggregating \$5,000 or more, are made by the Department of Agriculture. Additionally, where crop support and other Agriculture Department payments aggregate \$600 or more, those amounts are routinely reported to the Internal Revenue Service. *81-88*

Against that background, the staff requested the Department of Health, Education, and Welfare to prepare separate listings of health care practitioners paid \$25,000 or more, directly or indirectly by either medicare or medicaid in 1968.

The incomplete and partial listings indicated that at least 4,300 individual practitioners plus an additional 900 physician groups each received at least \$25,000 from medicare in 1968. The solo practitioners included at least 68 who were known to have received \$100,000 or more.

Following receipt of the names of physicians paid \$25,000 or more under medicaid, the Bureau of Health Insurance was requested to supply the amounts, if any, also paid those same physicians by medicare. (That was done because a physician who received \$100,000 from medicaid might have received less than \$25,000 from medicare and would not, therefore, have appeared on the medicare listings.)

The combined listings—by amounts paid and type of practice—appear in appendix B, p. 163. The data—which the staff emphasizes is partial and incomplete—reveal that both programs are reimbursing many physicians many thousands of dollars each.

See page

Hundreds of the payments profiles indicate that the physicians involved might be abusing the program. For example, we found many general practitioners each paid \$15,000, \$20,000, or more for laboratory services. We found large payments being made for what appear to be inordinate numbers of injections. In many cases, we found what is apparently overvisiting and gang-visiting of patients in hospitals and nursing homes.

The staff believes that the majority of physicians on whom information was gathered provided medically necessary services for which they were entitled to charge and be reimbursed. On the other hand, medicare's payments structure did little to discourage—in fact it encouraged—high fees, and thus may well have contributed to the very substantial payment totals to those same physicians.

In sum, it appears absolutely necessary that each carrier under medicare and each State's medicaid administrator be required to regularly compile and evaluate basic payments profile information with respect to each health care practitioner. The questionnaire developed by the staff undoubtedly can be modified and improved into a more effective screening device. Nonetheless, the kinds of data requested in the staff's rather elementary questionnaire are those which tend to indicate patterns of overutilization and overcharging.

Shortcomings exist with respect to the present capacity of the Government and its agent-carriers to undertake complete and professional evaluation and followup on their own of the specific data gathered on thousands of health care practitioners who were paid large sums under medicare and medicaid. It might be appropriate, therefore, to consult with and enlist the support of all professional organizations concerned which might be helpful in evaluation and follow-up programs. However, procedures which involve peer review by professional associations should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token.

The staff would also suggest that each State be routinely and regularly provided medicare payments profile data with respect to physicians practicing in that State. Such information would enhance the State's utilization and cost control capacity in its medicaid program inasmuch as many physicians serving medicare beneficiaries also care for medicaid recipients.

8. Incentive Reimbursement Methods for Hospitals, Extended Care Facilities and Physicians Under Medicare

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With a view toward spurring increased efficiency and economy in the medicare and medicaid programs, the staff is working to perfect an incentive reimbursement system. We believe that effective incentives to improved performance will result if better-than-average performance is rewarded

with a money payment—the better the cost control the larger the payment. This premise parallels (if it is not the same as) that underlying the competitive enterprise system—better performance and efficiency of operation yields higher returns. *See pages*

We believe also that to be workable an incentive reimbursement system must recognize the role of the physician as the key to controlling major portions of health care costs. It is the physician who determines whether a patient is to be hospitalized or placed in an extended care facility. It is the physician who determines the patient's length of stay in a health care institution or a hospital. It is the physician who orders the endless variety of costly services—such as X-rays, laboratory services, and drugs—which are provided to the hospitalized patient.

The theory on which our work is progressing involves a sharing with the providers of health care of a portion of the savings to the medicare program growing out of their increased efficiency and greater control over utilization in the future as compared to the first 3 years of operation of medicare.

We also believe that to be effective, an incentive must include a disincentive to continued poor performance.

It is our hope that our recommendation for an incentive reimbursement system can be submitted to the committee at an early date, and that it will stimulate the public discussion and consideration which must precede serious legislative action on so important and sensitive a matter.

9. Certification of Extended Care Facilities

With the inclusion of posthospital extended care benefits *91-96* under medicare, the Congress introduced a new concept into the hospital insurance program; an alternative, less costly institutional setting for the provision of medical care. The benefit was intended to encompass an "extension" of hospital care—care which in the absence of an extended care setting might otherwise have to be provided in the hospital. Extended care was not a term denoting duration—but rather a type of care somewhat less intensive and comprehensive than that ordinarily provided the acutely ill patient in the hospital. It was a type of care not ordinarily provided by nursing homes.

Congress intended that extended care facilities meet requirements designed for convalescent and rehabilitative care of high quality. The "conditions of participation"—requirements to be met by a facility in order to qualify—were drafted by the Department of Health, Education, and Welfare on a basis consistent with the congressional intent.

Despite the high standards, in the actual process of certifying facilities, nursing homes have not been required to fully meet the conditions of participation. Rather, in applying these standards, all that has been required is "substantial

See pages compliance" and progress toward full compliance. Some facilities were certified as in "substantial compliance" which could not, by any reasonable criteria, be considered to be without serious deficiencies.

With respect to this problem, the staff recommends that certification of facilities with deficiencies—other than those of an insignificant and minor nature—be prohibited.

The statute permits a "distinct part" of an institution rather than the entirety to be certified as an extended care facility, so as to encompass hospital wings or distinct infirmary sections with a high level of care in nursing homes. But the provision has been used in another way.

About 800 nursing homes have had a portion of their institution certified as an ECF. The vast majority of these are not in full compliance with the standards. At present, there need be no physical separation of beds or appropriate accounting separation of costs and it is difficult to determine which personnel work where. This enables homes to increase or decrease the number of beds designated as "extended care" so as to maximize medicare reimbursement. Surplus or unoccupied beds tend to be arbitrarily designated as "extended care" beds with resultant excess apportionment of costs to medicare.

The Secretary of Health, Education, and Welfare called attention to this problem in his Second Annual Report on medicare. To our knowledge no action has, however, been taken to date to remedy the situation.

The staff suggests that administration of the "distinct part" provision be modified to encompass only a physically and clearly distinct section of a practical size operated as a department with a separate nursing station. Further, clear accounting distinctions should be made for the "distinct part" and a reasonable vacant bed limitation applied which is not higher than the unoccupied bed ratio in the non-medicare portion of the facility.

10. Medicaid Skilled Nursing Home-Intermediate Care Facility Relationship

97-104 In a major effort to control rapidly rising skilled nursing home costs under medicaid, the Committee on Finance approved an amendment to the Social Security Act in 1967 to pay for care in an institution providing "services beyond room and board but below the level of skilled nursing homes." Such facilities were to serve as a lower-cost alternative to more expensive skilled nursing home or hospital care.

The service was intended according to the statute for those who: "* * * because of their physical or mental condition (or both) require living accommodations and care which, as a practical matter, can be made available to them only through institutional facilities: and do not have such illness, disease, injury, or other condition as to require the degree of care and treatment which a hospital or skilled nursing home

(as that term is employed in title XIX) is designed to provide." *See pages*

The committee report stated that the care was to be appropriate to the needs of the individual and that regular independent professional audit was to be made of his needs to assure that he was properly placed.

The congressional intent is not being fulfilled. Nursing homes have been reclassified as intermediate care facilities on a wholesale basis where they cannot or will not meet the standards required for participation as skilled nursing homes under medicaid. This approach appears designed more as an accommodation of substandard institutions than to encourage development of reduced levels of care appropriate to the needs of persons capable of being transferred from skilled nursing homes and mental hospitals.

Perhaps of greater importance is that the independent professional or medical audit—required in the case of skilled nursing home patients—is often not rendered in the case of each patient to determine that *his* needs would best be served in that particular intermediate care facility.

Quite simply, contrary to the letter and intent of the law, facilities and patients are classified as "intermediate" care on a wholesale basis. Furthermore, in several States, including Massachusetts, Rhode Island, and Ohio, many intermediate care facilities are being paid for care at rates greater than those paid to many skilled nursing homes participating in medicaid in the same areas. Again, this is expressly contrary to the congressional intent that intermediate care was to be a less costly alternative to skilled nursing home care. It is certainly inconsistent to pay more for services in a facility which by law is an institution in which a lower level of care is provided, than in an institution which, also by law, requires a higher level of care.

The staff recommends that appropriate legislative action or administrative action by the Department of Health, Education, and Welfare be taken to prohibit payments to intermediate care facilities at the same or greater rates than those made to skilled nursing homes in an area. The Department should also be requested to assure that States do not ignore the statute and congressional intent with respect to independent medical or professional determinations that the needs of a particular person can best be met in an intermediate care facility.

11. Institutional Utilization Review Mechanisms

One of the important provisions which Congress included 105-
in the original medicare law as a control and safeguard on 112
unnecessary and excessive usage of institutional care was the requirement that each participating hospital and extended care facility have a utilization review plan.

The detailed information which the staff has collected and developed indicates clearly that the utilization review

See pages requirements have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. One State medical society described the present situation in these words: "Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token."

Widespread failure to effectively apply utilization review results from several factors:

1. The regulations which have been issued on institutional utilization review requirements are not in accordance with the terms and intent of the statute.

2. Certification of hospitals and extended care facilities for participation in the program have been continued by the State health agencies and the Department of Health, Education, and Welfare despite the fact that basic statutory requirements have not been met by those institutions.

3. Many intermediaries under the program have either ignored or been negligent in assuring that institutions have functioning and effective utilization review mechanisms.

4. The Social Security Administration has made little effort to verify that contracting agents—State health agencies and intermediaries—carry out the terms of their contracts on this point.

In addition to improving administration of the present institutional utilization review requirements, certain legislative changes might be considered which could further improve the review process. Some possible changes are:

1. Where feasible, have the physician positions on a utilization review committee for a particular hospital filled by physicians associated with another hospital.

2. Require that utilization review plans for extended care facilities be organized outside the institution, either through a hospital affiliation, the local medical society, or the local health departments.

3. By appropriate Federal and State legislation, exempt health care practitioners from legal liability for decisions made during required utilization review or medical audit activity.

4. Require intermediaries to employ and apply local, regional, and possibly national utilization criteria in evaluating the provision of institutional services.

5. Offer homemaker benefits, on a demonstration basis initially, as an alternative to more costly institutional care. The homemaker benefits, while chargeable as a home health benefit, would be distinct from the services presently available from home health agencies.

12. Medicare Fiscal Intermediaries

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Under the law, groups or associations of providers of services—hospitals, extended care facilities, and home health

agencies—can nominate an organization to act as “fiscal intermediary” between them and the Government.

The Department of Health, Education, and Welfare may not enter into an agreement with any intermediary unless the Secretary finds that use of the intermediary is consistent with “effective and efficient administration” and the intermediary is able and willing to assist providers in the application of safeguards against unnecessary utilization of services.

Most nonprofit community hospitals nominated the Blue Cross Association as intermediary through their membership in the American Hospital Association. Somewhat more than one-half of the extended care facilities also nominated Blue Cross as intermediary.

A number of serious problems and issues related to intermediary nomination and performance have come to the attention of the staff.

1. Inasmuch as providers select the intermediary, some intermediaries have been reluctant to apply positive administrative requirements with respect to costs and utilization review for fear of losing the providers’ nomination. Other intermediaries have apparently solicited providers with implicit promises of preferential treatment. Some intermediaries also sell insurance to the providers they serve—creating an implicit conflict of interest situation.

In this regard, the staff concludes that the original purpose of the provision for provider nomination of intermediaries has been largely served. With the maturation of medicare consideration should be given, in order to avoid the types of problems discussed above, to authorizing the Secretary of Health, Education, and Welfare to designate intermediaries under part A as he now selects carriers under part B.

2. The Blue Cross Association is the prime contractor as intermediary with the Bureau of Health Insurance. The association seeks to coordinate the activities of the many local Blue Cross plans who actually function as intermediaries. The system which the association has established has been criticized as often constituting an additional, costly, and duplicative layer of administration. The administrative capacity of individual Blue Cross plans ranges widely—yet the Bureau of Health Insurance has so far taken the good plans with the poor ones under this all-or-none prime contract arrangement with the Blue Cross Association.

The Bureau of Health Insurance should in any subsequent contracts with the Blue Cross Association reserve and exercise the right to select as local intermediaries only those Blue Cross plans which are capable of proper and efficient performance. Social Security regional offices should also have authority to deal directly with local Blue Cross plans on medicare matters without the necessity of routing all but the most nominal inquiries through the offices of the Blue Cross Association.

See pages

3. Intermediary performance varies widely with respect to processing time on medicare bills, the proportion of bills returned from Social Security to intermediaries because of errors, the proportion of bills pending for long periods of time and administrative costs.

The performance of some intermediaries appears so much below average that serious consideration of replacement by a better performing intermediary seems called for. That process would be facilitated if the intermediary nominating procedure was modified as the staff suggests.

13. Medicare Carriers

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Medicare carriers are selected by the Secretary of HEW to process and make payment for part B claims and to serve as a channel of communication between the Bureau of Health Insurance and those furnishing services covered under the Supplementary Medical Insurance Plan.

Carrier performance under medicare has in the majority of instances been erratic, inefficient, costly and inconsistent with congressional intent. The Bureau of Health Insurance has taken little action to weed out and terminate the inefficient carrier. Extensive comparative data collected for the staff clearly indicates wide variation and frequent low levels of performance.

Unquestionably many millions of dollars of public funds have gone to subsidize carrier inefficiency. Some of this expense was unavoidable but much of it could, the staff believes, have been avoided through alert, aware, and prompt action by the Social Security Administration. While millions of dollars invested in inefficient carriers, thus far, would be lost through termination, the staff believes that the Government (and the older citizens who pay half of those costs) would gain far more in the long run by replacing them now. What appears needed are fewer carriers and a benefits and administrative structure lending itself to genuine competition for appointment to the job of medicare agent.

A number of Blue Shield plans initially refused to comply with that part of the instruction by social security to identify, by name, physicians who had been paid \$25,000 or more by medicare in 1968. Most of the plans which declined to provide the information requested said that they had not been "authorized to do so by the physicians involved."

Clearly, the issue raised did not involve "authorization" by physicians. The staff could find no provisions in law, regulation or carrier contracts which provided that identification would not be made to the Federal Government except with express physician "authorization."

The underlying concern of those Blue Shield plans which resisted providing names is understandable. Blue Shield works with and depends upon the goodwill of physicians for much of the success it enjoys in its regular day-to-day business where in most instances it actually contracts with indi-

vidual doctors. In medicare, however, the contract is with the United States Government. The Government's obligation is to undertake such procedures as will assist in assuring its citizens—particularly the millions of elderly who pay premiums—that their money is being properly expended. *See pages*

The Government is "trustee" of the part B trust fund. The staff stresses that its concern is with the basic issue of public accountability—not with any advocacy of publication of the names of individual physicians and the amounts paid them. As we previously suggested in item 7, the staff believes identification by name of physicians receiving large payments is vital to any serious effort at cost and utilization control.

14. The Quality of Administration of Medicare

A number of areas of administrative laxity by Social Security in implementing, operating, and supervising medicare have been previously noted. Other areas where improvement in performance seems necessary are in the quality of information supplied to and requested of carriers and intermediaries as well as in present program evaluation and research activities. 121-
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In response to staff questionnaires, carriers, and intermediaries frequently indicated their belief that Bureau of Health Insurance instructions were not issued in timely fashion, were often too voluminous and detailed, and not written in clear and concise fashion with appropriate examples. Those comments (unidentified as to source) have been turned over to the Social Security Administration for their use in improving their instructions. The staff, on the other hand, is not unaware that some of the carrier and intermediary criticism may have been self-serving and intended to gloss over their own poor performance.

One of the more important elements in appraising administrative performance is the quality of the research and program evaluation effort. One of the most important uses of program statistical data—sound cost estimating—deserves mention because some 3½ years after the start of medicare, they are still based on incomplete program experience and only utilization estimates are based upon any substantial program data. Principle causes of the delay in securing data arise from the fact that so few hospital accounting periods have been finally settled, and from an ineffective and cumbersome health insurance research effort.

The staff concludes that the present health insurance research and program evaluation effort needs to be substantially revised. In this connection the following suggestions are made:

1. Health insurance research directly related to day-to-day evaluation of program administration should be given the highest priority and should be placed in the Bureau of Health Insurance as an administrative control under the authority of the Director of the Bureau of Health Insurance.
2. Program data useful for cost-estimating purposes should be given a priority only slightly lower than program evalua-

See pages tion data and should be designed and analyzed by the Office of the Chief Actuary.

3. Health insurance research related to the impact of the program on beneficiaries and the health industry should have the next priority and should be carried out, as now, under the direction of the Office of Research and Statistics.

4. Contractors with the program—carriers, intermediaries, and State agencies—should be relieved of as much data gathering and report making as possible consistent with the objectives of the research and should be the regular recipients of analyses of data which might be useful to improvement of their performance.

15. Medicaid Administration

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There are serious and costly deficiencies in the operation, administration and supervision of the medicaid program. The typical medicaid patterns are slow payment to suppliers of health care goods and services; little effective effort to determine whether those goods or services were necessary (or even given); little or no control over recipient abuse; and, general laxity of administration. Findings of the HEW Audit Agency, reviews of State programs made by the Medical Services Administration (the HEW agency responsible for overseeing medicaid), General Accounting Office reports and those of various individual State agencies, as well as staff conferences with State legislators, administrators, and others—all underpin the negative conclusions of the staff.

The recommendations which follow may serve as the basis for committee consideration of methods of improving medicaid. Another key element, however, is essential if the program is to function as intended. While the Medical Services Administration probably requires additional personnel if effective Federal supervision is to be realized, it appears vital that any additional and present personnel—including officials—operate with a greater sense of responsibility and direct involvement than has been manifested heretofore. The Medical Services Administration needs dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as medicaid is to be soundly administered.

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The staff recommends the following actions to improve the medicaid program:

1. Require usage of fee schedules for payment of health care practitioners.
2. Reduce drug costs through adoption of the type of amendment offered by Senator Russell B. Long in 1967 which was approved by the Senate but not enacted at that time.
3. Curb overutilization by requiring prior professional approval of elective procedures and expensive courses of treatment.

4. End costly "doctor shopping" by recipients through requiring designation by the recipient of a "primary physician." *See pages*

5. Facilitate reporting and detection of abuse and fraud by requiring States to provide medicaid recipients with statements outlining payments made in their behalf.

6. Modify present law so as to make practicable reasonable cost-sharing payments by the medically indigent.

7. Prohibit making of vendor payments to independent collection and discount agencies to whom providers have sold their medicaid or medicare due bills.

8. Improve Federal administration and supervision as well as establish formal and informal cooperative arrangements with and between States.

9. Establish a medicaid fraud and abuse unit in HEW.

10. Require States to maintain specific organizational units for the prevention, detection, and investigation of fraud and abuse in their health care programs.

11. Combine the Medical Assistance Advisory Council with the Health Insurance Benefits Advisory Council into a single body to facilitate coordination and communication in the two principal Federal health care financing programs.

16. Other Areas of Actual and Potential Abuse in Medicare and Medicaid

Concern has been expressed by many existing health care institutions and others over the tremendous growth in chain operation and construction of medical facilities and their acquisition of related companies. *135-143*

Certainly, no case can or should be made solely because of size against an organization which limits its activity to a number (even a large number) of a single type of health care facility—such as skilled nursing homes. In such instances, where the chain operates beds which are needed in a community and without the presence of conflicts of interest, opportunities exist for significant economies and efficiency in the provision of necessary health care. The problems arise with respect to the overpromoted chains consisting of conglomerations of various types of health care facilities and services where, in the final analysis, the Government, in the main, is expected to recognize for reimbursement inflated prices paid by those chains in their eagerness to expand and demonstrate growth, presumably in order to generate demand for their stock.

Other hospitals and skilled nursing homes are being built or proposed for communities where existing facilities are adequate to serve the needs of those areas. In most instances, this construction is not subject to approval of areawide planning agencies and if prior experience is any yardstick, if a bed is available, it will be filled.

In the above instances, bona fide competition does not occur with respect to whether one facility is more efficient and

economical than another. What competition does exist is for scarce health manpower and patients—both generating further upward pressure on already high costs.

In the competition for paying patients, several of the largest chains, deliberately follow a policy of selling stock to local physicians as a means of assuring that the new facility will get paying patients. Unquestionably, many physicians, who have an ownership interest in a facility, are not motivated by that interest in their treatment of patients. Nonetheless, there is always the appearance of a potential or implicit conflict-of-interest in physician ownership of a health care facility or service in which he treats his patients in terms of admissions policy, the range and frequency of services supplied, and dates of patient discharge.

There is a requirement in title 19 of the Social Security Act that States maintain a current list of owners of interests of 10 percent or more in skilled nursing homes. The staff requested those lists, and then, on a sample basis due to the massive amount of material received, cross-checked on physician-owners of nursing homes who had also received payments of \$25,000 or more from medicare in 1968. A number of these physicians with financial interests in skilled nursing homes and in some cases proprietary hospitals as well showed unusual amounts and patterns of charges. In particular the frequency of visits to institutionalized patients and the aggregate amounts billed for such visits as well as for injections and laboratory services indicate an obvious need for thorough followup.

In addition to efforts to have unusually high cost bases recognized for purposes of medicare reimbursement, some chains (as well as some consulting firms who own stock in institutions for which they consult) have also sought acceptance as reimbursable costs of unusually high salary, franchise fee, percentage of gross-income, and purchases from related organization arrangements. Social Security has recently stepped up its efforts to detect and prevent abuse in those areas and that activity is certainly justified and worth while.

Another area of concern which has implications, not only for medicare and medicaid, but also for the tax collector, involves a trend toward changing the status of a proprietary health care facility to that of a "nonprofit" institution. For example, a group of physicians who own a proprietary hospital with a depreciated replacement cost of \$2 million might claim a "fair market value" of \$4 million (inclusion of goodwill, etc.) and sell it for that sum to a nonprofit organization which they in fact control. The purchase price is to be paid from the excess of cash flow over expenses of the hospital. Prior to the transfer of ownership, the hospital may have had average net income of \$200,000 subject to ordinary tax. That \$200,000 excess of income over expenses now becomes tax free and can be applied toward payment of the inflated \$4 million purchase price (along with other

items of cash flow such as depreciation) where, in large part, it becomes subject to capital gains tax rates rather than ordinary income rates. *See pages*

A principal problem in these situations is that, under existing law, it is debatable whether the Internal Revenue Service can deny tax-exempt status to nonprofit hospitals or nursing homes engaging in transactions of this type, particularly where there is allegedly arm's-length dealing.

It is suggested that the committee consider requesting the Department of the Treasury to submit such legislative proposals or other recommendations as may be deemed necessary to avoid abuse of tax-exempt status and capital gains treatment in the sale or exchange of health care facilities. Particularly, the Treasury should suggest means of valuing such facilities which do not possess manipulative potential.

With respect to asset valuations for purposes of reimbursement under medicare and medicaid, the staff has recommended earlier in this report that "goodwill" not be recognized as an element of cost where a transfer of ownership occurs. Further, depreciation expense should be recognized only on the same basis as in the tax laws—straight-line historical cost.

17. Reporting of Medical Payments to Tax Collector

Until very recently, insurance companies (including those participating in medicare), many Blue Cross-Blue Shield organizations, State agencies participating in the medicaid program, and employers and unions having self-insured or self-administered health plans did not file information returns with the Internal Revenue Service when they made payments to (or with respect to) doctors, dentists, and other suppliers of medical and health care services and goods on behalf of individuals. 145-
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On November 13, 1969, largely in response to views previously expressed during hearings before the Committee on Finance (Hearings on Medicare and Medicaid, July 1 and 2, 1969), the Internal Revenue Service revoked its prior policy and announced that henceforth information returns would be required with respect to payments aggregating \$600 or more made to a doctor or other provider. Payments made to corporations (including professional service corporations set up by doctors for tax purposes) were specifically excepted from this reporting requirement.

No doubt this change in attitude by the Internal Revenue Service and the publication of its new position requiring information returns with respect to medical payments made to doctors and other providers prompted the conferees on the Tax Reform Act to omit a Senate amendment added to the bill by the Committee on Finance before the Service position was reversed. This Senate amendment called for detailed reporting of medical payments, including payments

made to an insured person, either in reimbursement for payments he had made to a doctor or other provider, or with respect to services performed by the doctor or other provider.

The staff believes the present requirements of the Internal Revenue Service leave much to be desired. As already noted, they do not cover payments made to corporations. Nor do they cover the so-called indirect payments—those payments made to the insured who receives the amount, either as reimbursement for payment he has already made, or who presumably will use the proceeds in settlement of an unpaid bill. The staff views this shortcoming of the present reporting requirement as a substantial defect which can lead to massive shifts in billing practices by doctors and other providers of health care services seeking to avoid having their payments reported to the tax collector. Such a shift could also have serious implications with respect to the patient who may be unable to pay his doctor first and then seek reimbursement under his health insurance policy.

Another important defect in the new reporting requirements concerns the inability of the Internal Revenue Service to require the payer to furnish the doctor or other provider of medical services, goods, or supplies with a copy of the information return or similar statement. We believe it is important that the doctor or other provider be informed of the amount reported to the Internal Revenue Service as having been paid with respect to services he rendered or goods and supplies he furnished.

Yet another defect in the new reporting requirements is their failure to impose a reporting responsibility upon payees acting as conduits and who, in fact, merely transfer the insurance proceeds to the taxpayer actually rendering the services. For example, many clinics or associations of doctors may designate a single doctor to receive payment for services rendered by all the doctors in the clinic or association. The same could be true of doctors who join together in a professional service corporation for the practice of medicine. The staff believes the information required under the new Internal Revenue Service requirement will not be very useful as an enforcement device because IRS cannot know which doctor received what portion of a consolidated group payment.

Unfortunately, these defects largely reflect shortcomings in the statute itself, and few if any of them can be corrected by further administrative action.

Probably the most serious shortcoming of the present reporting requirement, however, concerns whether it is supported by the present law. The applicable statute (section 6041 of the Internal Revenue Code) requires "all persons engaged in a trade or business and making payments in the course of such trade or business" to render a true and accurate return reporting payments to another person aggregating

\$600 or more during the year. It has been argued that payments paid by an insurance company to or on behalf of a private citizen for health care goods and services are not encompassed by this language. Rather it is argued that the insurance company, in such cases, merely acts as the agent of the private citizen. And, pursuing the analogy, since the private citizen is not required to report payments he makes to his doctor for services rendered to him, neither is the insurance company.

The Internal Revenue Service position with respect to this question is stated as follows in the Revenue Ruling announcing the new reporting requirement:

Payments of fees under the plans, programs, or policies here considered to doctors or other suppliers of health care services are made in the course of the trade or business of the persons making the payment. Accordingly, it is held that such persons are required to file forms 1099 with respect to such payments made directly to doctors or other suppliers. (Revenue Ruling 69-595—Nov. 13, 1969.)

The staff has already observed that the new reporting requirement fails to require reports of indirect payments (those made to a private person to be repaid, to a doctor or other provider). At this point we express the fear that the controversy described in the two immediately preceding paragraphs could develop into litigation which might place the validity of the present reporting requirement in doubt for years to come.

With payer of dividends and interest now required to report payments to a person aggregating \$10 or more during the year (with additional statements required of nominees identifying the principal to whom they repaid the amounts) the present reporting requirements with respect to medical payments seems particularly inadequate. In the opinion of the staff the committee should consider again the sort of comprehensive amendment it added to the Tax Reform Act. That amendment corrects and overcomes the defects in the new administrative reporting requirement and would provide the Internal Revenue Service with information vastly more useful to it in enforcing the tax laws of the Nation.

CHAPTER ONE

FISCAL IMPACT OF MEDICARE

The Medicare law enacted in 1965 included benefits under two parts:

(1) Part A, Hospital Insurance, provided hospital benefits and extended care and home health benefits after hospitalization; and

(2) Part B, Supplementary Medical Insurance, paid part of the cost of doctors' services, diagnostic services (such as X-rays and laboratory tests), and home health services (even without prior hospitalization).

The hospital insurance program under Part A was to be financed through an employer-employee tax at a combined rate of 0.7 percent of taxable wages in 1966, rising to 1.0 percent in 1967-1972 to an ultimate rate of 1.6 percent in 1987 and thereafter. The tax was to apply to only the first \$6,600 of annual wages. Half of the cost of the Supplementary Medical Insurance program under Part B was to be borne by the enrollee, and the other half of the cost was to be matched from Federal general funds. At the start of the program, July 1, 1966, the enrollee's monthly premium was set at \$3.

Hospital Insurance

In 1965, when the medicare program was enacted into law, the hospital insurance program was estimated to cost 1.23 percent of taxable payroll over a 25-year period. Almost all of this was attributable to hospital benefits. Benefit payments for 1970 were projected at \$3,116 million (including benefits for all medicare eligibles); 1990 benefits were projected at \$8,797 million.

During congressional deliberation on the 1967 Social Security Amendments, the 1965 actuarial estimates were thoroughly reevaluated. On the basis of that reevaluation, the actuarial cost estimate over a 25-year period was raised to 1.54 percent of taxable payroll (with a \$6,600 tax base) rather than 1.23 percent—a 25-percent increase. The actuarial deficit of -0.31 percent combined with the low scheduled contribution rates in the early years of operation, meant that the Hospital Insurance Trust Fund would be exhausted in 1970 unless Congress took steps to shore up the program's financing.

Minor changes in the benefit structure in the 1967 amendments had virtually no effect on the long-range cost estimates. But two steps were taken to strengthen the actuarial soundness of the hospital insurance program: (1) The taxable wage base was increased from \$6,600 to \$7,800, and (2) the combined employer-employee tax rate was raised 0.2 percent per year above the scheduled rates in prior law. These two financing measures were estimated to bring the hospital insurance program into close actuarial balance (with an 0.03-percent long-range surplus). With a higher wage base and thus a

larger taxable payroll, the long-range cost was now estimated at 1.38 percent of taxable payroll over the 25-year period. Benefit payments for 1970 were now estimated at \$4,441 million; for 1990, they were projected at \$10,843 million.

Again in early 1969, the actuarial cost estimates were reevaluated, and new estimates were incorporated in the 1969 report of the Hospital Insurance Trust Fund trustees. For the first time, actuarial assumptions were at least partly based on actual program experience.

The increase in projected program costs was dramatic. The cost was now estimated at 1.79 percent of taxable payroll over the next 25 years; 1970 benefit payments were estimated at \$5,029 million, and 1990 benefit payments were projected at \$16,830 million—in both cases, almost twice the original estimates. The Hospital Insurance Trust Fund was estimated to have an actuarial deficit of —0.29 percent; the trust fund would under the prevailing contribution schedule (including the 1967 increase) be exhausted by 1976.

In September 1969 the program costs were projected again on a preliminary basis, by the Social Security Chief Actuary. Previous estimates were dwarfed by the new projections, which set the cost at 2.27 percent of taxable payroll over the next 25 years—and an actuarial deficit of —0.77 percent, the equivalent of \$126 billion, about half of estimated receipts under present law during the 25-year period. The actuarial deficit has been increased to —0.80 percent (an additional —0.03) due to December 1969 liberalizations in the reimbursement formula for hospitals. In dollars, the 25-year shortfall under present financing becomes \$131 billion. The trust fund is now projected to become exhausted by 1973 unless additional financing is provided.

A comparison of the actuarial estimates made in 1965, 1967, and January and September 1969 is shown in table 1 below.

TABLE 1.—*Hospital insurance benefit cost projections*

[In billions of dollars]

	Estimate of 1970 costs	Estimate of 1975 costs	Estimate of 1990 costs
Actuarial estimate made in 1965.....	3. 1	4. 3	8. 8
Actuarial estimate made in 1967.....	4. 4	5. 8	10. 8
Actuarial estimate made in January 1969.....	5. 0	7. 6	16. 8
Current estimate.....	5. 8	(¹)	(¹)

¹ Unavailable.

Basically, the significant underestimates made in 1965 were the result of basing cost projections on then recent utilization and cost experience. In fact, the actuarial assumptions accepted by the Congress generally were deliberately more conservative than that experience warranted. Unfortunately, utilization rates and inflationary and other cost increases under medicare far exceeded the experience before 1965. Thus, the increases in cost estimates should be viewed as indicative not of poor actuarial assumptions, but rather as indicative of inflationary pressures and a serious lack of effective utilization and cost controls in administering the medicare program.

The major elements of the actuarial estimates are discussed below.

Rising Hospital Costs and Increasing Hospital Utilization

In 1965, actuarial estimates of hospital costs were based on the assumption that in any year, 21.7 percent of the 19 million persons covered by hospital insurance would be hospitalized, with an average hospital stay of 14.55 days covered under the program. On the average, this would represent a utilization rate of 3.16 days of hospitalization per year per eligible person (whether or not he was actually hospitalized). It should be noted that this utilization rate was deliberately set 20 percent higher than the original actuarial estimates of the Administration in order to allow for possibly higher utilization. Based on then current experience, it was assumed that average daily hospital costs under the program would be \$40.06 in 1966; daily costs would increase 5.7 percent annually until 1970, with the annual increase declining to a stable level of 3 percent beginning in 1975. Throughout the period, wages in employment covered under social security were projected to increase by 3 percent annually. Thus, under the original actuarial estimates made in 1965, hospital costs were expected to rise 2.7 percentage points faster per year than wages until 1970; the differential would diminish over the next 5 years and disappear by 1975.

Under the 1965 actuarial assumptions, the cost of hospital benefits in 1967 would be the product of 19 million beneficiaries times 3.16 hospital days per person times \$42.38 per day of hospitalization (5.7 percent more than the 1966 daily rate), or about \$2½ billion. This figure would be decreased by about \$200 million, the share of the cost paid by the beneficiary (primarily from payment of what was then a \$40 deductible). The actual expenditures in calendar year 1967 would be somewhat lower than incurred costs because of the lag between receipt of services and payment for them.

By 1967, it had become clear that hospital costs were increasing far more rapidly than the assumed 5.7 percent per year. New actuarial estimates continued the 1965 assumptions that average wages in covered employment would increase by 3 percent annually, and that hospital costs would increase by the same annual rate beginning in 1975; but the annual rate of hospital cost increases was raised drastically for years before then. Hospital costs were now based on an average daily cost of \$44.28 in 1967, estimated to increase 15 percent annually in 1968, 10 percent in 1969, and 6 percent in 1970, with the rate of increase declining to 3 percent—the same increase assumed for wages—by 1975. Since actual program data were not yet available, no change was made in the 1965 utilization rate assumption of 3.16 days of hospitalization per enrollee per year.

Reevaluation of the actuarial estimates in January 1969 showed that both hospital cost increases and utilization rates had been underestimated in the light of the preliminary program experience that was finally becoming available. (Delays in getting final cost data are discussed later in the report.) Average daily hospital costs had increased 12.3 percent in 1967, and using an average daily cost of \$44.76 in 1967, this figure was estimated to increase 13 percent in 1968, 12 percent in 1969, 9 percent in 1970, and by declining amounts until a stable annual increase of 3.5 percent was reached in 1975. Under these estimates, the average daily hospital cost would be about \$62 in 1970, \$70 in 1972, \$80 in 1975, and over \$100 by 1982. The

utilization rate was increased from the earlier estimate of 3.16 hospital days per enrollee per year to 3.8 days—a 20-percent increase in the rate used in the assumptions. The actual average hospital cost in 1967 (including cost-sharing payments by beneficiaries) had been \$170 per beneficiary (3.8 days of hospitalization per beneficiary times \$44.76 daily hospital cost) compared with the \$134 projected for 1967 in the 1965 actuarial estimates (3.16 hospital days per beneficiary times \$42.38 daily hospital cost)—an actual cost per beneficiary in 1967 which was 27 percent higher than the 1965 projection. The cost per beneficiary projected for 1970 in the 1965 estimates was \$158 (3.16 days of hospitalization per beneficiary times \$50.05 daily hospital cost) compared with the \$235 projected in the current estimates (3.8 days of hospitalization per beneficiary times \$61.75 daily hospital cost)—almost a 50-percent increase.

In September 1969 the actuarial assumptions were again revised upward. Increases in hospital per diem costs were raised to 15 percent in 1969, 14 percent in 1970, 13 percent in 1971, and by declining amounts until a stable annual increase of 4 percent after 1977. More important, the new estimates for the first time assume that hospital utilization rates will increase over the next decade by an average of about 1 percent annually (higher rates during the first few years). The cost per beneficiary estimated for 1970 is now \$273—about 70 percent higher than the estimate for that year made in 1965.

The changing assumptions for average *daily* hospital costs are shown in table 2 below; the changing assumptions for the average *annual* hospital cost per beneficiary are shown in table 3.

TABLE 2.—Average daily hospital costs

	Estimate of 1967 daily hospital costs	Estimate of 1970 daily hospital costs
Actuarial estimate made in 1965.....	\$42. 38	\$50. 05
Actuarial estimate made in 1967.....	44. 28	59. 37
Actuarial estimate made in January 1969.....	44. 76	61. 75
Actuarial estimate made in September 1969.....	44. 76	67. 48

TABLE 3.—Average annual hospital cost per beneficiary

	Average days of hospitalization per year	Estimate of 1967 annual cost per beneficiary	Estimate of 1970 annual cost per beneficiary
Actuarial estimate made in 1965..	3. 16	\$134	\$158
Actuarial estimate made in 1967..	3. 16	140	188
Actuarial estimate made in January 1969.....	3. 8	170	235
Actuarial estimate made in September 1969.....	(¹)	170	273

¹ 3.8 days in 1967, increasing on the average by 1 percent per year over next decade.

Assumption of Constant Wage Base Under Attack

It should be noted that, although the actuarial estimates for hospital insurance have assumed that wages will rise over the next 25 years,

it is assumed that the taxable wage base will not increase above the specified levels written in law at the time the actuarial estimate is made. This policy was specifically decided upon by the Congress when medicare was first enacted in 1965.

Prior to enactment of medicare, actuarial estimates of the cost of hospital insurance proposals assumed that the Congress would from time to time increase the wage base to keep pace with rising earnings. The Congress in 1965 rejected this assumption. The Finance Committee report on the medicare bill in 1965 stated:

"Perhaps the major consideration in making and in presenting these actuarial cost estimates for hospitalization benefits is that—unlike the situation in regard to cost estimates for the monthly cash benefits, where the result is the opposite—an unfavorable cost result is shown when total earnings levels rise, unless the provisions of the system are kept up to date (insofar as the maximum taxable earnings base and the dollar amounts of any deductibles are concerned). * * *

"The committee very strongly believes that the financing basis of the new hospital insurance program should be developed on a conservative basis. * * *

"In all the previous cost estimates, it was assumed that the maximum taxable earnings base would be kept up to date, by periodic changes, with changes in the general earnings level. * * * The committee believes that this is not a conservative assumption, since it seems to bind future Congresses into taking action in order to maintain the actuarial soundness of the hospital insurance system. It should be emphasized that the actuarial soundness of the cash benefits program under the old-age, survivors, and disability insurance system does not at all depend upon an assumption of the earnings base being adjusted upward when wages rise (but rather, on the contrary, the actuarial status of the system is improved under such circumstances). Accordingly, although the committee believes that, under the likely conditions of rising wages over the next 25 years, the earnings base will be adjusted upward beyond the increases contained in the committee-approved bill (from the present \$4,800 to \$6,600), the conservative assumption should be made for the purposes of the actuarial cost estimates that no further increases will occur after 1966.

"As indicated previously, one of the most important basic assumptions in the cost estimates presented here is that the earnings base is assumed to remain unchanged after it increases to \$6,600 in 1966, even though for the period considered (up to 1990) the general earnings level is assumed to rise at a rate of 3 percent annually. If the earnings base does rise in the future to keep up to date with the general earnings level, then the contribution rates required would be lower than those scheduled in the committee-approved bill. In fact, if this were to occur, the steps in the contribution schedule beyond the combined employer-employee rate of 1.1 percent would not be needed. Furthermore, under the foregoing conditions, if the hospital utilization experience followed the intermediate-cost assumptions made previously in Actuarial Study No. 59 of the Social Security Administration (increased by 10 percent for the estimates presented in this report),

and if all other conditions (such as the relationship of hospitalization costs and general earnings) developed as they are set forth in the assumptions, then it is possible that the combined employer-employee contribution rate would not have to increase beyond 1 percent." (89th Cong., S. Rept. 404, pt. I, pp. 59-66.)

In their 1969 report on the status of the Hospital Insurance Trust Fund, the trustees of that fund noted the long-range actuarial deficit of -0.29 percent of taxable wages. Disregarding the legislative history outlined above, the trustees suggest that the hospital insurance trust fund actually has an actuarial surplus of 0.07 percent, "if the reasonable assumption that the earnings base will be kept up to date is made." This contention minimizing the trust fund's serious financial difficulties is difficult to accept, particularly since the Congress made clear in 1965 that it considered a reduction in medicare taxes just as "reasonable" an assumption as "keeping the earnings base up to date." After all, an increase in the wage base does not increase an individual's medicare benefits—it just increases his taxes. Unhappily, even the 1967 cost assumptions did not prove conservative enough, and further congressional action is now necessary to provide additional financing. Considering the fate of the actuarial estimates during the first few years of the program, including the major upward revisions in January and September of 1969, it would seem particularly inappropriate at this time to accept the trustees' recommendation to eliminate the conservative bias in the level wage base assumption in the actuarial estimates.

It should be noted that the President has recommended a 55-percent increase in hospital insurance taxes to restore the actuarial soundness of the program. While part of the increase would be achieved by raising the tax rate, much of the tax rise would be linked to automatic increases in the wage base as earnings levels rise. Such steps would have the effect of preempting future taxing capacity which the Congress might otherwise want to use to broaden medicare benefits.

Substantial Increase in Utilization of Extended Care Facilities

In 1965, the administration's medicare proposal included 60 days of medical care in an extended care facility following at least 1 day of hospitalization. The Secretary of Health, Education, and Welfare made clear in his testimony before the House Ways and Means Committee that an extended care facility was to be one which provided post-hospital skilled nursing and rehabilitative care and *not* "the long-term custodial care furnished in many nursing homes." (1965 House hearings, p. 4.)

The actuarial estimates for Social Security eligibles, which were made for H.R. 1, the 1965 administration bill, assumed that hospital insurance eligibles would spend an average of 0.16 days per year in extended care facilities in 1967, increasing annually until a utilization rate of 0.31 days per year was reached. The actuary specifically stated that these utilization rates assumed that "benefits will be provided in accordance with a strict interpretation of language in the bill" (1965 House hearings p. 440), which made clear that this benefit was intended as a medical alternative to hospitalization in a sub-hospital setting and was not meant to include domiciliary-type extended care.

The actuarial estimates further assumed, on the basis of recent experience, that daily costs would average \$11.26 and would increase thereafter at 3 percent per year. Thus, for 1967, total extended care facility benefits were estimated at about \$30 million during the first full year (0.16 day per enrollee times \$11.26 per day times about 16½ million insured people). It was then assumed that hospital benefit costs could be reduced by some portion of the \$30 million extended care facility benefit costs "in anticipation that the inclusion of these benefits would reduce hospital utilization"—the net cost of the extended care facility benefit was estimated at about \$25 million. (1965 House hearings, p. 438.)

It is interesting to note that the insurance industry disagreed sharply with these assumptions in 1965. Specifically, they felt that the utilization rate would average 1.01 days per year per enrollee in 1967—more than six times the rate assumed in the actuarial estimates—and that they would rise to an ultimate level of 1.66 days per year. The industry stated that their projected utilization rates were based on experience "under plans with a very tight definition of extended care facility and with a requirement of at least 5 days of prior hospitalization * * *. Passage of H.R. 1 will cause beneficiaries now insured for posthospital extended care benefits to drop this protection. If the program is then administered so tightly that their present actual utilization rate of 1.01 days is cut to 0.16 day, these beneficiaries will have lost valuable protection. Furthermore, the heavy outlay for nursing home care under medical assistance for the aged (the Kerr-Mills program) will scarcely be reduced if H.R. 1 is so tightly administered." (1965 House hearings, p. 440.) The insurance industry based its daily extended care facility costs on a rate of \$12.60 per day in 1967, increasing 4 percent per year until 1978 and 3 percent annually thereafter. Thus, the industry estimated a 1967 cost of \$210 million for extended care facility benefits for insured persons (1.01 days per enrollee times \$12.60 per day times about 16½ million enrollees). The insurance industry did *not* agree that hospital benefit costs would be reduced because of the provision of extended care facility benefits; on the contrary, they asserted that the requirement of prior hospitalization would "so increase hospital admissions as to offset any such savings."

The medicare law actually enacted provided 100 rather than 60 days of care in an extended care facility, required at least 3 days of prior hospitalization, and (unlike the administration bill) required the beneficiary to pay a portion of the cost after the 20th day. Because of the general uncertainties of estimating the cost of this new type of benefit, the first-year (1967) costs were estimated by Social Security to range between \$25 and \$50 million. Though ECF costs were not separated from hospital costs in the actuarial estimates, it was assumed that the ECF costs over the long run would represent about 4 percent of hospital costs.

Experience under the program soon began to show that the insurance industry's utilization rate estimate was quite accurate: enrollees averaged 1 day per year in extended care facilities. The principal reason was that the major actuarial assumption, that a tight definition of extended care facility benefits would be adhered to, proved false. Literally thousands more beds were certified under the medicare pro-

gram than the actuary had assumed. By the middle of the first year, more than 4,000 nursing homes had been certified as extended care facilities under medicare—about a thousand of them on a “temporary” basis because they could not meet medicare standards.

In view of this unanticipated development, the actuarial estimates of ECF benefit costs were completely revised in 1967. Based on experience in the first quarter of the calendar year, 1967 costs for both insured and non-insured persons were estimated at \$275 million. This figure was increased in subsequent years by the same percentages as hospital daily costs were assumed to go up. It was assumed that any increased utilization of extended care facilities would be offset by roughly equal savings in hospital costs.

In response to a question by Senator Anderson in the course of the Finance Committee’s hearing on the 1967 Social Security Amendments, the Chief Actuary of the Social Security Administration stated:

“At least part of the reason for the underestimate of first-year costs arose from the fact that far more qualifying ECF beds were available than I had estimated. It is still far too early to judge the extent to which the availability of this larger number of ECF beds has decreased hospital utilization over what it otherwise would have been—and it may well never be possible to make such a determination. In my opinion, it is highly desirable to make a thorough medical study of ECF utilization—as is now being done—so as to determine what it should properly be.” (1967 Senate hearings, pp. 358–359.)

The actual 1967 average daily ECF costs of \$18.16 were far higher than either the original actuarial estimate of \$11.27 or the insurance industry’s estimate of \$12.60—both based on then recent experience.

As actual program experience became available, the actuary was forced to revise his estimates completely again in late 1968; his new assumptions are incorporated in the 1969 trustees’ report.

The most striking basic change was the actuary’s rejection of his original assumption (based on congressional intent) that the hospital costs could be specifically reduced by some amount because of beneficiary utilization of extended care facilities. The January 1969 actuarial estimates simply dealt with hospital costs and ECF costs separately. Starting with the 1967 actual experience of average daily ECF costs of \$18.16, the estimates assumed a 12-percent increase in 1968, a 10-percent increase in 1969, an 8.7-percent increase in 1970, and diminishing increases leveling off at 3.5 percent annually beginning in 1975.

The 1967 utilization rate of 1 day per year per enrollee was increased 13 percent in 1968, 14 percent in 1969, 13 percent in 1970, and by diminishing amounts until 1976, after which no increase in the utilization rate was assumed (by that date, the rate would have reached 2.22 days per year, 122 percent more than the 1967 rate). Based on actual experience, the actuarial estimates assumed that insured persons will pay 17.2 percent of the total covered charges as their coinsurance.

Thus in 1970, the estimates assumed incurred costs of about \$590 million (1.46 days per enrollee times \$24.35 per day times about 20 million enrollees equals \$710 million, from which should be subtracted 17.2 percent representing the coinsurance paid by the beneficiaries).

Recent actions to establish controls on utilization of extended care benefits permitted the actuary in September 1969 to reduce slightly the utilization rate increases he had projected in January of that year.

Home Health Services Utilization Much Higher Than Anticipated

In the absence of adequate information, the actuarial estimates in both 1965 and 1967 assumed a first-year cost of about 50 cents per eligible person for posthospital home health services under the hospital insurance program. This represented a \$10 million cost in 1967. It was assumed that home health services would result in some hospitalization cost savings.

Actual costs in 1967 were about $2\frac{1}{2}$ times that figure, and the 1969 revised actuarial estimates start with a base cost figure of \$1.30 per enrollee for 1967. Both per capita costs and utilization rates are assumed to increase by the same percentages as extended care facility utilization and daily costs are projected to rise. At these rates of increase, the per capita cost of home health services will jump from \$1.30 in 1967 to \$1.83 in 1970, and to \$2.39 by 1975.

Supplementary Medical Insurance (Part B)

The financing of the supplementary medical insurance program is different from that for the cash benefit and hospital insurance programs in several fundamental respects. First, the premium rate for any period is required by law to be set at such an amount that income from premiums and Government matching contributions accrued in the period is estimated to be sufficient to cover the benefit payments and processing costs related to all services furnished during that period. In this way, those enrolled in the program during any period for which a particular premium rate is applicable will, as a group, pay for half the cost of the services that they as a group receive during that period. Thus costs are measured on an accrued (incurred) basis when the services are provided, rather than on a cash basis, when the services are paid for.

Second, the financing of the program is set only for short periods into the future, so that there is no need for long-term projections of the experience of the program. (The premium rate for each fiscal year period is promulgated before the January 1 that marks the beginning of such year.) Further, there is no natural accumulation of an excess of income over disbursements as the covered population matures. Consequently, there is greater urgency that the cash income exceed the cash disbursements in the period for which the experience is projected (although the natural lag in the payment of benefits results in a cash balance which provides some margin) to assure enough assets on hand at any time to pay benefits should the premium prove inadequate by a small margin.

Rising Physician Fees

Over 90 percent of the benefit payments under supplementary medical insurance are for physicians' services, and it is largely on the basis of these services that the actuarial estimates of the cost of the program have been made. Under the law, the beneficiary must an-

nually pay the first \$50 toward the cost of covered services, plus 20 percent of additional costs.

In the 10 years between 1956 and 1965, physicians' fees rose an average of 3 percent annually. Accordingly, the 1965 actuarial estimates assumed a continuation of this rate of increase. It was estimated that benefit payments plus administrative expenses for the first year and a half of the program would total slightly less than \$6 per month per enrollee (half of which was to be paid by the enrollee).

In actual experience, the \$6 estimate proved insufficient in 1966-67. Thus in setting the new premium rate to begin in 1968, it was necessary both to pay for the full costs incurred during the 15-month period the new premium would be in effect and also to make up to some extent for the deficit incurred while the \$3 premium was in effect.

However, physicians' fees between June 1965 and June 1967 actually rose at an annual rate of 6.5 percent per year compared to the 3 percent average rate of the previous 10 years which had been used in the 1965 actuarial estimates. In setting the premium which was to go into effect in April 1968, a new assumption was made that physicians' fees would rise at the rate of 5 percent per year between July 1967 and July 1969, and by 3 percent per year thereafter. Of course, these percentages were with respect to the rate of rise in charges by physicians to the total population and not on the basis of charges to the 65 and over population. Conceivably, the rate of rise in physicians' charges to older patients was higher than the overall increase in charges.

The long term trend of increasing use of physician services per capita has amounted to somewhat less than 1 percent per year; the actuarial estimates used in setting the new 1968 premium assumed an increase in utilization of 2 percent per year between July 1967 and July 1969 and of 1 percent per year thereafter. As a result of these estimates, the new premium rate was set at \$4 per month beginning April 1968.

In late 1968, new actuarial estimates were made to determine the premium to be assessed between July 1969 and June 1970. Unfortunately, there was still little information available on incurred costs except for the first 6 months of the program (July-December 1966). Based on the estimated accrued costs, however, the supplementary medical insurance program had operated at a deficit during each of its first 3 years: a \$15 million deficit in 1966; \$109 million deficit in 1967, and \$31 million deficit in 1968, for an accumulated deficit of \$155 million by the end of 1968. Since there was a substantial delay in the submission and payment of bills the Supplementary Medical Insurance Trust Fund on a cash basis had \$421 million at the end of 1968.

Between June 1967 and June 1968, physicians' fees rose 5.5 percent (compared with the 5 percent increase previously estimated). The late 1968 actuarial estimate assumed that physicians' fees would increase 5 percent in 1969, 4.5 percent in 1970, and 3.5 percent in 1971. It was assumed in 1968 that utilization of services would increase 2 percent in 1968 and 1969 and 1½ percent per year thereafter (compared with the earlier estimate of 1 percent per year after 1969). Based on these assumptions, it was projected that the program would cost an average of about \$106 per year per enrollee, requiring a \$4.40 monthly premium from each insured person. Despite the actuarial estimates, the Secretary of HEW retained the premium at a \$4 level on the assump-

tion that either (1) there would be no increase in physician fees or utilization of services between July 1969 and June 1970, or (2) reimbursement would much more often than in the past be based on less than the full charge. Under the actuarial estimates, a \$4 premium would result in about a \$180 million deficit on an accrued basis in fiscal year 1970.

The Secretary of HEW announced in December 1969, that the monthly part B premium rate will be increased, as of July 1, 1970, to \$5.30. This increase will require additional annual premiums from Federal general funds and the elderly totalling about \$600 million.

Unanticipated Increase in Administrative Costs

Though only a relatively small proportion of the total cost of the medicare program, administrative costs have been subject to the same problem of unanticipated increases as have the benefit payments.

The President's budget for fiscal year 1968, for example, anticipated a need of \$44 million for part A intermediaries (insurance companies and Blue Cross plans that handle hospital insurance claims) and \$66.2 million for part B carriers (insurance companies and Blue Shield plans that handle supplementary medical insurance claims) a total of \$110.2 million. These funds soon proved insufficient, and when a special \$25 million contingency fund was also exhausted, a supplemental appropriation was sought. The actual fiscal 1968 budget was \$55.3 million for part A intermediaries (26 percent more than the original estimate) and \$88.2 million for part B carriers (48 percent more than the original estimate), a total of \$153.5 million.

In fiscal year 1969, the story was much the same. The President's budget included \$60.8 million for part A intermediaries and \$89 million for part B carriers, a total of \$149.8 million. As in fiscal year 1968, use of a special \$25 million contingency fund was necessary. Again, this was not enough. A \$16.5 million supplemental appropriation was sought, and was approved by the House. In the Senate, another \$4.7 million was added to this amount because the Department of Health, Education, and Welfare determined that a further additional amount was needed. The actual cost was \$76.0 million for part A intermediaries (26 percent more than the original estimate) and \$117.4 million for part B carriers (32 percent more than the original estimate), a total of \$193.4 million.

CHAPTER TWO

FISCAL IMPACT OF MEDICAID

Legislative Developments Before Medicaid

Federal participation in the cost of providing medical care to needy persons began when the Federal Emergency Relief Administration between 1933 and 1935 made available to the States funds to pay the medical expenses of the needy unemployed. The Social Security Act of 1935 set up the public assistance programs and, while no special provision was made for medical assistance, the Federal Government paid a share of the monthly assistance payments, which could be used to meet the cost of medical care. However, the payment was made to the assistance recipient rather than to the provider of medical care.

It was in 1950 that Congress first authorized "vendor payments" for medical care—payments from the welfare agency directly to physicians, health care institutions, and other providers of medical services. Federal sharing was liberalized in subsequent amendments, and by 1960 four-fifths of the States made provision for medical vendor payments. In 1951, vendor payments for medical care totaled slightly more than \$100 million; by the end of the decade, they had increased to over one-half billion dollars. More than half of the total was spent under Old Age Assistance.

A new category of assistance recipient was established by Congress in 1960: the "medically needy" aged, whose incomes were greater than that which would have qualified them for cash assistance payments, but who needed help in meeting the costs of medical care. The Federal Government would pay from 50 to 80 percent of the cost of Medical Assistance for the Aged, established under the new Kerr-Mills Act, and provision was made for liberalized Federal sharing in vendor payments for medical care under Old-Age Assistance.

Between 1960 and 1965, total medical vendor payments more than doubled, from about \$1½ billion to \$1.3 billion. Increases in vendor payments under Old-Age Assistance and the new Kerr-Mills program accounted for almost all of the increase.

Enactment of Medicaid

In 1965, a new medical assistance (medicaid) program was enacted as a part of the Social Security Amendments of 1965 (which also included medicare). The medicaid program had these features:

(1) It substituted a single program of medical assistance for the vendor payments under the categorical cash assistance and Medical Assistance for the Aged programs, with a requirement that beginning in January 1970 Federal sharing in vendor payments would be provided only under the medicaid program;

(2) It offered all States a higher rate of Federal matching for vendor payments for medical care;

(3) It required each State to cover all persons receiving or eligible to receive cash assistance;

(4) It permitted States to include medically needy blind, disabled, and dependent children and their families (as well as the medically needy aged) at the option of the State; and

(5) It required that States include inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services, and permitted other forms of health care at State option.

Six States began operation of their medicaid programs in January 1966, the earliest possible date. California began its program in March 1966, with New York initiating medicaid in May. By the end of 1966, 26 States had plans in operation. Another 11 began their medicaid programs during 1967. As of January 1, 1970, all States, with the exception of Alaska and Arizona had medicaid programs in operation or expected to commence shortly.

Early Fiscal Impact of the Medicaid Program

The Department of Health, Education, and Welfare had estimated at the time Congress was considering the legislation that the Medicaid program would cost the Federal Government an additional \$238 million in its first full year of operation. In fact, the Federal share of vendor payments for calendar year 1966 was precisely \$238 million more than in calendar year 1965—but only six States had programs in operation during the full year.

Thus it soon became clear that the medicaid program would be more expensive than originally contemplated. But just how much more expensive it would be was not known until later.

In January 1967, the President's budget predicted that 48 States would have medicaid programs in operation by July 1, 1968, and that total payments would be \$2.25 billion in fiscal year 1968. By January 1968—midway through the fiscal year—only 37 States had medicaid programs in operation, but the vendor payment cost estimate for fiscal year 1968 had risen to \$3.41 billion. Actual expenditures, with 37 States having medicaid programs, were \$3.54 billion.

Congressional Action

Congressional concern over rapidly rising medicaid costs led to legislative action in 1967. (House Committee action in 1966 had come too late in the session for floor action). The House chose as its basic method of cost control limiting the definition of "medically needy" (for purposes of Federal matching) to persons whose income did not exceed 133 $\frac{1}{3}$ percent of the maximum payments for similar size families under programs of Aid to Families with Dependent Children. The Committee on Finance recommended and the Senate approved an alternative to the House approach which would have provided a substantially lower Federal matching percentage for the medically needy than for persons receiving cash assistance payments. The House provision was accepted in conference and became law.

In December 1967, the House and Senate Conferees were told by the Department of Health, Education, and Welfare that Federal Medicaid costs would total \$1.9 billion in fiscal year 1969 and \$3.1 billion by fiscal year 1972, *if there were no change in the law*. The restrictions in the 1967 Amendments, the Conferees were told, would reduce these estimates to \$1.6 billion in 1969 and \$1.7 billion in 1972.

Scarcely a month later, members of the Finance Committee were surprised to learn that the President's budget included \$2.1 billion in Federal funds for Medicaid in fiscal year 1969—\$200 million more than had been previously estimated without changing the law, and one-half billion dollars more than the estimate with the 1967 amendment. Fiscal year 1969 Federal costs totaled \$2.3 billion—almost 50 percent more for that year than the estimate of the Department of Health, Education, and Welfare in December 1967.

Congressional concern with the operation of the Medicaid program continued in 1969. The Department of Health, Education, and Welfare, through an erroneous interpretation of the statute, was forbidding the States from reducing the scope of their Medicaid programs as a fiscal response to the sharply rising costs of health care. A Finance Committee amendment (sponsored by Senators Anderson and Gore) was approved by the Senate and enacted by the Congress to correct this situation and allow the States to make orderly retrenchment in their Medicaid programs, provided the modifications were not undertaken for the purpose of enabling larger payments to be made to providers of services still covered by the plan and provided cost control programs were implemented by the States.

This amendment also suspended for 2 years the July 1, 1975 goal of comprehensive Medicaid programs. The Department of Health, Education, and Welfare had insisted that the States constantly move toward higher and higher levels of Medicaid care and coverage.

"With a view toward furnishing by July 1, 1975, comprehensive care and services to substantially all individuals who meet the plan's eligibility standards with respect to income and resources, including services to enable such individuals to attain or retain independence or self-care" (sec. 1903(e), Social Security Act).

The committee felt that with the cost of health care rising so sharply and with many States in financial difficulty because of their Medicaid programs, it would be preferable to reassess the July 1975 goal in connection with an overall review of Medicare and Medicaid following completion of the staff's study of these programs. With that thought in mind the July 1, 1975 date in section 1903(e) of the Social Security Act was moved to July 1, 1977.

Current Outlook

The fiscal 1970 budget submitted in January 1969 estimated Federal Medicaid costs at \$3.1 billion. As part of its April budget review, the new Administration proposed reductions of \$141 million through administrative actions. Another \$238 million reduction in Medicaid appropriations results from States re-estimates; but about half of this total simply represents a shifting of costs for nursing home care from Medicaid to the new intermediate care facility program under Old Age

Assistance. Thus it is unlikely that the estimate of Federal costs will be reduced by more than one-quarter billion dollars—if indeed the Administration is successful in cutting costs and the State re-estimates are correct.

Fiscal Impact of Medicaid on the States

Increasing Medicaid costs have had a particularly severe fiscal impact on the States. Welfare costs typically constitute one of the largest items in the State budget, and vendor payments for medical care have represented an increasing share of welfare costs. In fiscal year 1965, just before Medicaid's enactment, medical assistance represented 25% of total Federal, State and local welfare costs (excluding administrative costs). Over a four-year period, this percentage has risen to 41%. Looking at State and local funds only, medical vendor payments have risen over the four-year period from less than one-third to almost one-half of welfare expenditures (excluding costs of administration). In absolute dollar terms, the rise has been precipitous: from \$764 million in State and local funds for medical vendor payments in fiscal year 1965 to an estimated \$1,896 million in fiscal year 1968—a 150% increase within four years.

A questionnaire prepared by the staff was sent each Governor asking whether current Medicaid estimates were greater than earlier projected costs for the same years. About half of the States whose Medicaid programs were initiated in 1966 or 1967 responded that Medicaid costs are exceeding earlier projections. In a few States, the costs are not exceeding earlier estimates only because the program has been cut back to fit within appropriation ceilings.

The questionnaire also asked whether Medicaid cost increases had forced the State to increase taxes, reduce other State programs, or take other action. One-third of the States initiating a Medicaid program in 1966 or 1967 have raised State taxes at least in part due to Medicaid costs; a number of Governors stated that the tax increases in their States could be directly linked to greater-than-anticipated Medicaid costs. Several Governors attributed either cutbacks in other State programs or curtailment of growth in other programs directly to increased Medicaid costs.

One-third of the States that initiated Medicaid programs in 1966 or 1967 have instituted or are planning to institute cutbacks in the scope or coverage of their Medicaid programs as a result of cost increases.

CHAPTER THREE

REIMBURSEMENT OF INSTITUTIONS PROVIDING MEDICAL CARE

Background: Congressional Concern and Lack of Data

Section 1814(b) of the Social Security Act requires that payment for covered services (under either part A or part B) provided by hospitals, extended care facilities, and home health agencies be made on the basis of "reasonable cost." The term "reasonable cost" is defined under section 1861(v) of the act. This latter section sets out general guidelines for the Secretary of Health, Education, and Welfare to follow in issuing the detailed regulations governing reasonable cost reimbursement.

The Committee on Finance held an executive hearing in May 1966 on several issues arising from the proposed HEW regulations on reimbursement. Some of the issues raised in those hearings are still unresolved and are discussed below along with issues which arose subsequently.

The Congress, and the Finance Committee in particular, wanted to review the whole question of reimbursement again in 1967 at the time it considered the 1967 social security amendments. However, the Department of Health, Education, and Welfare urged a delay since the basic data needed to make proper evaluation of the effect of the reimbursement regulations were not yet available.

The Senate approved an amendment in 1967 which would have given a provider of services under the medicare program the option of being paid on a per diem basis for inpatient services. Although the Senate receded on the amendment in conference, the Conference Report noted that it was the understanding of the conferees for both the House and the Senate that the action was not to be taken as a final decision respecting the issues surrounding reimbursement of providers of services. Rather, it was the sense of the conferees that decisions on these issues should not be made until the actual costs incurred under the program had been finally determined. The Department of Health, Education, and Welfare was directed to furnish such costs data to the respective committees as soon as it was available. Unfortunately the committees have not as yet, more than 2 years after that conference, received those data. The staff did ask (in 1969) for the information but was advised that it was not compiled; that the Social Security Administration has "available for tabulation the first 1,400 audited cost reports for short term hospitals." This, however, represents only 22 percent of the 6,400 participating short-term hospitals for the first cost reporting periods. And, Commissioner Robert M. Ball stated that there is no assurance that those first 1,400 reports are representative of the total. Thus, after more than 3 full years of

operations under the program, data adequate to assess existing cost reimbursement regulations are still not available. While the staff was informed that 93 percent of the cost reports "are in the processing pipeline," it is not indicated when the process will be complete.

The staff did review an analysis based on data gathered by the American Hospital Association¹ which indicate that in general the financial position of hospitals—the excess of their revenues over expenditures—improved during the first 18 months of medicare. The small and medium-sized hospitals, which have the largest proportions of aged patients, showed the greatest improvement in their financial positions.

The American Hospital Association has for many years reported total revenues and total expenditures data in the annual Guide Issue of its publication "Hospitals." However, in 1969, while continuing to include data on hospital costs, it stopped reporting the comparable amounts of hospital revenues.

Comprehensive assessment of the financial status of hospitals in light of the medicare reimbursement formula and related regulations will have to await more complete data than are now available in usable form. However, extensive discussion with representatives of hospitals and extended care facilities, as well as with Bureau of Health Insurance personnel, indicates consensus concerning a need for ultimate revisions—liberalizing and restricting—in both reimbursement procedures and the formula itself.

Making "Reasonable Cost" More Reasonable

The basic direction in any changes will presumably be toward more equitable reimbursement—from the standpoint of both Government and providers—coupled with simplified and coordinated cost reporting requirements.

There are a number of particular areas where medicare reimbursement might be modified in the interest of equity. For example, where a given hospital can demonstrate that it provides more nursing care to older patients and incurs greater costs thereby, the additional expense incurred by that hospital should be recognized and appropriately reimbursed. Similarly, where a particular institution makes a satisfactory showing that clerical or other personnel regularly spend a disproportionate amount of their working time in servicing records or patients under the medicare program, in contrast to other patients in the same facility, that disproportion (assuming it does not result from inefficiency) should be acknowledged in calculating reimbursement to that institution.

Blanket recognition of reimbursement factors such as increased nursing and clerical time should be avoided. In December, 1969, the Social Security Administration announced that it would allow *all* hospitals an additional 8½ percent above the amounts previously payable for nursing costs. Such factors will vary—in some cases substantially—from institution to institution. Recognizing that it might be difficult and costly to undertake institution-by-institution studies, nonetheless, differentiation by size and type of facility in a

¹ "Financial Position of Hospitals in the Early Medicare Period," Feldstein and Waldman, *Social Security Bulletin*, October 1968.

given area should be feasible. However, it would be illogical to include a nursing-time "plus factor" for institutions which do not fully meet the conditions of medicare participation—particularly those with staffing deficiencies. Of course, if a greater proportion of nursing time costs is allowed for the over-65 population (medicare) then obviously a reduced proportion would be allocable to the under-65 population (medicaid).

Keeping Down the Cost of Determining Costs

Cost-finding and auditing have proved highly expensive undertakings in the medicare program as well as being a source of much friction. The legislative history indicates congressional concern that proper cost-accounting be required not only for proper determinations of payment but also as desirable and necessary adjuncts of good management. The staff does not believe, however, that the Congress intended accounting and audit "overkill" in pursuit of those objectives.

The Bureau of Health Insurance should be encouraged in its efforts to revise procedures so as to avoid requiring what in essence amounts to duplicate cost-finding on the part of hospitals. To the extent possible, costs data developed for other third-party payors such as Blue Cross, as well as other accounting data prepared in the course of an institution's routine operation, should, wherever feasible, and subject to audit, be coordinated with medicare accounting requirements so that one set of records and one audit may suffice. Additionally, less extensive and simpler costs data might be required of smaller institutions than larger ones. The latter suggestion is not made simply because of the greater difficulty in providing data which is encountered in smaller facilities but also because the ratio of accounting and audit costs to benefit costs can become disproportionate in those cases.

Reducing Expensive Delays in Final Settlement

Among the problems which have arisen in medicare reimbursement are the inordinate delays in final financial settlement with participating medicare facilities and arbitrary interim payment procedures, which occasionally result in either overgenerous or inadequate payments. In other cases, hospitals and extended care facilities have complained of extensive delays in securing payments from intermediaries.

So as to encourage prompt payment and settlement as well as realistic rates of interim reimbursement, the staff suggests: (a) that the Government pay interest on any amounts due to an institution which are unpaid more than 60 or 90 days after the institution has properly submitted adequate data upon which final settlement may be made following the close of its cost-reporting period; (b) that a similar rate of interest be payable to the program by the institution (and considered a nonreimbursable expense) on the average interim overpayment, allowing for reasonable variation during the cost reporting period, and continuing until the submission of proper costs data to the intermediary for such period.

Incentive Reimbursement Instead of Cost-Plus Reimbursement

The pursuit of equitable reimbursement as a worthwhile goal would not, we believe, be served by any cost-plus method of payment,

except where the "plus" factor was related, on an incentive basis, to economical performance.

The staff has expressed concern about cost-plus reimbursement ever since it was first proposed for medicare by the Social Security Administration in the spring of 1966. The committee will recall the 1966 report submitted to it on this subject and the executive hearing on the proposed reimbursement formula which it held in May 1966. As one Governor put it in response to the staff questionnaire, that type of reimbursement "* * * contains no incentives whatsoever for good management and almost begs for poor management." That comment is predicated upon the fact that under cost-plus reimbursement, the higher a facility's costs—the greater its bonus.

The National Governors' Conference and the Advisory Commission on Intergovernmental Relations have also formally criticized the cost-plus medicare and medicaid reimbursement formula.

Two-Percent Bonus Counter to Needed Planning Efforts

The 2-percent bonus on top of accounted-for costs was added to medicare reimbursement by HEW regulation in 1966; it was subsequently removed by HEW regulation in 1969. The bonus had been rationalized as a "growth" factor by hospitals and by Social Security as an allowance for costs actually incurred but unidentifiable due to problems in cost-finding during the initial stages of medicare. Either way, the bonus was not justifiable, in our opinion.

Possibly, the Federal Government, along with all purchasers of hospital care should help meet certain identified and approved capital needs of nonprofit hospitals where such needs cannot otherwise be met through depreciation allowances, contributions, regular borrowings, existing Federal programs, etc. But any significant capital improvement financed in whole or part by the Federal Government should be contingent upon approval of an appropriate community or State planning body broadly representative of all of the various types of health care and services. A broadly representative and qualified planning group would avoid the pitfall encountered in the Hill-Burton program, of determining hospital and nursing home bed needs without allowance for reduced bed needs through greater development and emphasis upon alternative out-patient services. The review agency, of course, should not be dominated by any single type of facility or service. Specifically, hospitals should not control the planning and approval mechanism. Decisions to approve capital expenditures should be made only after thorough consideration has been given to existing and alternative health care resources already available or approved in a given community or medical service area. Simply stated, the capital expenditure should be necessary in the context of the priorities for meeting overall community needs.

The October 1969 issue of *Hospital Trustee*, a publication of the American Hospital Association, contains some pertinent comments relative to the need for proper planning in an article entitled "Needed . . . New Approaches to Providing Nursing Home Care." The article was written by William S. McNary, for many years president of the Michigan Blue Cross plan, and presently executive director of the Greater Detroit Area Hospital Council, Inc. In the piece, Mr. McNary noted:

"Many believe that there is an urgent need for more acute care hospital beds. I happen to agree with Odin Anderson, Ph. D., professor and associate director of the University of Chicago Center for Health Administration Studies, who holds that the 740,000 general hospital beds we now have are sufficient and that the resultant bed-population ratio should be maintained, not increased. Anderson says that hospitals currently are adding 20,000 beds annually against a need for only 11,000. If they build those 9,000 extra beds every year, today's construction arithmetic shows that hospitals will be wasting \$300 million a year in capital investment. These 9,000 surplus beds, in turn, will call for the expenditure of perhaps \$200 million a year in operating expenses—a situation that will be even more wasteful than the capital expenditure because it will make scarce manpower even scarcer and more costly. If hospitals remain silent and permit the purchase of these unneeded general hospital beds, the blame for this waste of money can largely be laid at their door. They must, instead, propose, plan, and produce a thrifty alternative."

Given the fantastically high and still-increasing costs of institutional care it would not appear rational for the Federal Government to provide a "growth" factor related only to the costs of providing care in health care institutions. That policy only encourages duplication, overlapping, and unnecessary expansion of facilities and services. Basically, what is needed is a means of differentiating between justifiable capital requirements in one institution and unjustified demands for capital contribution by another facility. A rigid cost-plus formula does not make that kind of vital distinction. For example, under the formula in effect until July 1, 1969, the newest hospital generated the greatest amount of depreciation and received 2 percent of that depreciation expense as a "growth" factor. Yet an older facility, with far greater and justifiable capital needs, might have received minimal depreciation reimbursement coupled with a much smaller 2-percent bonus payment.

Legislative Proposal Designed To Control Costs

Legislation already before the committee (S. 1195) contains provisions designed to provide a basis for moderate and reasonable controls on payments to hospitals and extended care facilities under medicare and medicaid. First, medicare would not pay more on a costs basis than the institution's customary charges to the general public for the same services. Thus, if the medicare formula developed costs of \$80 a day and the hospital's charges were only \$75, payment would be limited to the latter amount. Second, no payments would be made under medicare to the extent that a hospital's average per diem operating costs (noncapital expenses) under the medicare formula exceed those of the previous year by more than the annual percentage increase in the Medical Care Price Index for that geographic or metropolitan area. The Secretary of HEW could allow full payment, despite the limitation, in certain unusual and atypical cost increasing situations such as where a hospital assumes additional responsibilities as a teaching institution, which it had not previously carried. Third, medicare and medicaid would not reimburse any costs associated with a capital

expenditure of \$100,000 or more for plant or equipment (except routine replacement of equipment) where the expenditure was specifically disapproved by a State's "partnership for health" agency or other appropriate and qualified planning agencies designated by a Governor. Rules such as these appear to provide far more orderly cost-control mechanisms and assurances than those now employed.

Additionally, consideration might be given to limiting reimbursement for care provided in a given institution to not more than a reasonable difference above the costs for comparable care and services in a similar institution in the same area. Of course, any such excess amounts not paid by the program or the beneficiary should not be picked up later as a reimbursable bad debt or recognized for matching purposes under medicaid.

Reimbursement of Hospital "Reasonable Costs" Under Medicaid

In their efforts to control the hospital segment of medicaid costs, States have been confronted with a barrier erected by the Department of Health, Education, and Welfare, based upon the Department's interpretation of the provision concerning reimbursement of hospitals under title 19 (medicaid) of the Social Security Act.

Under title 19, States are required to reimburse hospitals on the basis of "reasonable costs." No further discussion of that requirement appears in the title. Under title 18 (medicare) where "reasonable costs" payment to hospitals is mandated, there are extensive clarifying provisions as well as substantial discussion in the committee reports. Most important, however, is the fact that neither in the statute nor contemporaneous committee reports are any cross-references found requiring that hospital reimbursement under title 19 be identical to that under title 18.

The staff believes that it was the intent of the Congress that, as with many other welfare requirements, States would be permitted to define "reasonable costs" within general guidelines established by the Secretary of Health, Education, and Welfare. The medicare pattern of reimbursement—even its specific formula—could fall within those guidelines, but States would not be restricted to the medicare formula. Latitude in defining those costs would be afforded each State and the State's definition would be subject to the approval of the Secretary. This understanding seems reasonable in view of the differences between medicaid and medicare in terms of the ages of the populations assisted, sources of financing, and primary administrative responsibility. As it is, States are theoretically not permitted to depart from the medicare formula in paying hospitals under medicaid. However, at least one State, Connecticut, has challenged the Department. Connecticut maintains it now pays hospitals their full "reasonable costs" and that it would cost the State \$4 to \$5 million more annually if they had to pay under the medicare formula.

The staff questionnaire to Governors included the following question:

"Medicaid regulations require States to reimburse hospitals under medicaid on the same basis as they are reimbursed under

medicare. Does this reimbursement requirement impose any burden on your State? Please explain."

Responses included negative answers from 11 States: Colorado, Iowa, Maine, Michigan, Montana, Nebraska, New Hampshire, North Carolina, South Dakota, Tennessee, and Vermont.

"Yes" replies were received from 26 States: Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, Nevada, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Texas, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Arkansas: "* * * we expect that reimbursement of hospitals under title XVIII and title XIX on a full cost basis will create economic incentives for price inflation of hospital charges and every wasteful practice implicit in such cost-plus reimbursement."

Hawaii: "Under the principles of reimbursement, States are subjected to payments exceeding 100 percent of the cost at times and this method of reimbursement neither encourages provider institutions to practice economy of operations nor insure high quality care."

Massachusetts: "Financially, the payment of full costs is in effect a blank check to hospitals to meet any cost they may undertake."

Nevada: "The medicare patterns of payment for hospitals, nursing homes and doctor bills have most assuredly affected the cost of other health programs in our State if for no other reason than that the medicare patterns are inflationary in themselves."

New York: "This cost-plus formula compels us to reimburse hospitals for whatever costs they incur, regardless of the quality of their management practices. This open-ended mode of reimbursement contains no incentives whatever for hospitals to operate efficiently. We have developed a reimbursement criteria that would build in incentives to hold hospital costs down . . . we are not permitted to use them because of Federal reimbursement requirements."

Rhode Island: "* * * because of the two percent (2 percent) incentive and depreciation allowance the State in most cases pays over one hundred percent (100 percent) of charges at the time of final adjustment. This leads us to believe that we are paying more for the recipients of the program than the hospital would charge a non-recipient."

Washington: "During the year following implementation of the RCC formula, hospital per diem charges increased by about 40 percent."

Wyoming: "Reimbursement of hospitals under the medicare regulations imposes two burdens, both of which are very costly. First, cost of hospitalization increases when there is absolutely no incentive for efficiency. Second, the administrative cost, both to the hospital and to the agency, is extremely high and a complete waste of public funds."

The staff recommends that, with respect to the relationship between payments under medicare and reimbursement of hospitals under medicaid, congressional intent be clearly established.

Other Issues in Institutional Reimbursement

The staff has identified several additional problems in institutional cost reimbursement:

Paying for Empty Beds

Under the present cost reimbursement regulations it is possible for a hospital or extended care facility to be paid for the costs associated with all of its empty beds as well as those beds occupied by medicare beneficiaries. An illustration would be that of a 100-bed extended-care facility with only 10 of its beds occupied, all with medicare patients. In computing the costs of services rendered to the 10 medicare patients all of the costs arising from the empty beds can be paid for by medicare. The quite predictable result can be daily reimbursable costs approaching \$100. Theoretically, a newly-opened extended care facility could be assured of full reimbursement of all of its costs for the entire facility if it admitted just one medicare patient on its first day and that unreasonable rate of reimbursement would be available indefinitely. The regulations as now written contain no provisions to avoid such situations. Medicare makes investment virtually risk-free where it bears full costs. Thus, institutions may be built more freely—even where new or expanded bed capacity is not needed.

The staff recommends two changes in the reimbursement provisions to meet this problem: (1) medicare should limit payment to the lesser of costs or the published charges which a non-governmental institution would make to a patient paying his own bill, (2) medicare's share of costs associated with empty beds in the facility might be limited to the proportion of beds with medicare patients to the total number of beds. For example, if medicare patients on the average occupied 10 percent of the total beds during the cost reporting period medicare would pay no more than 10 percent of the costs arising from the empty beds in the facility. Alternatively, it might be possible to limit reimbursement for empty beds on the basis of normal occupancy levels for comparable institutions rather than actual occupancy in a particular facility.

Bad Debt Writeoff Can Undermine Cost-Sharing Principle

The deductible and copayment provisions of part A are intended as cost-sharing devices so that the beneficiary will pay a portion of the costs of his hospitalization (or extended care) and thereby reduce medicare expenses. To the extent that hospitals and extended care facilities cannot collect these payments from beneficiaries they are chargeable as bad debts and paid to the hospitals and extended care facilities by medicare.

Although the staff has received some information indicating that a number of institutions make virtually no effort at collection before the cost is passed on to medicare, it has been unable to determine the extent to which intermediaries are requiring that institutions make a genuine effort to collect debts attributable to medicare beneficiaries before charging those debts to the program as uncollectible.

The present \$52 deductible is expected to rise to \$84 by 1974—with commensurate increases in the other part A deductibles. As those deductible amounts are moved upward, they will constitute an increasingly significant cost. In that context then, it is important to medicare's finances that those amounts which can be collected are in

fact recovered, rather than simply charged off to the program following token effort at collection.

Reimbursement for bad-debts attributable to non-medicare patients is not allowable under medicare. Yet, social security, despite concern expressed to the agency by the General Accounting Office has authorized medicare payment of a proportionate share of collection costs of non-medicare bad debts. Such collection is frequently undertaken by independent collection agencies whose fees are based upon a percentage of the amount collected. Where such collection costs are recognized, medicare, in effect, is paying for non-medicare bad debts. The staff recommends termination of such payments.

Rapid Depreciation Allowances Can Lead to Bonanza

The liberal depreciation allowances payable under medicare—including accelerated depreciation—may well serve as an incentive to the sale and resale of proprietary facilities at inflated prices. The objective in such situations would be to repeat the writeoff of the facility and its equipment once again on the basis of accelerated depreciation and thereby realize inordinately high and duplicative cash payments from the Government.

This type of situation could occur where the owner of a property, originally valued at \$1 million for purposes of depreciation, sells it for the same amount at the end of 5 years. Assuming a 20-year life on the property, use of the sum-of-the-years digits method of calculating depreciation would yield about 45 percent—or \$450,000—in writeoffs during the first 5 years. The new owner, following a brief period of non-participation and reentry into the program, may then proceed to take accelerated depreciation on those same assets—valued at \$1 million to him. The property could change hands every few years with the Government eventually paying several times more than the original costs of the assets involved.

The acceptance of inflated cost bases and payment of liberal depreciation on those amounts may serve as incentives to wholesale entry by firm after firm into the hospital and nursing home field and their willingness to pay out-of-line prices (in stock and sometimes cash) for established facilities. And, this situation is conducive to transformation of proprietary facilities into “nonprofit” institutions with the owners selling out at a high price to the nominal nonprofit organization with payment of the purchase price to be made on an installment basis from the excess of revenues over expenses of the new “nonprofit” hospital.

The staff would suggest, therefore, that appropriate regulations be issued (and proper enforcement assured) providing for tightened appraisal procedures in determining value for reimbursement purposes when a facility changes ownership. In such appraisals, “good will” should not be recognized as an element of cost for reimbursement purposes. Further, where a change in ownership occurs, depreciation should be allowed only on a straight-line historical cost basis as is presently the case under the tax laws.

The Comptroller General has been requested to provide the committee with a review and analysis of the current depreciation situation in medicare. His report, expected to be available in March, 1970, will include possible alternative methods of calculating and reimbursing for depreciation expense.

CHAPTER FOUR

TAX-EXEMPT STATUS OF COMMUNITY HOSPITALS AND OBLIGATION TO PROVIDE CHARITABLE CARE

The staff believes the committee's attention should again be called to the potential cost implications for medicare, medicaid, and other public programs of Internal Revenue Service Ruling 69-545, announced on October 8, 1969. That ruling overturns earlier IRS decisions that a hospital, in order to qualify for tax exemption under section 501(c)(3) of the Internal Revenue Code must provide charitable or below-cost care to the extent of its financial ability.

The tax reform bill passed by the House of Representatives (H.R. 13270) also contained a provision which removed the charitable or below-cost care requirement as a condition of tax exemption for hospitals. Ruling 69-545 was issued subsequent to House passage of the tax bill. On October 28, 1969, the Finance Committee deleted the provision contained in the House bill, indicating that it desired to consider the question in the context of medicare and medicaid. The committee action was approved by the Senate and accepted by the House.

Prior to consideration of the House bill in the Senate, the Committee on Finance instructed the staff to summarize the various provisions in the bill and to describe the major arguments for and against the amendments contained in the bill. Insofar as this hospital amendment was concerned, this "Summary of H.R. 13270, the Tax Reform Act of 1969 (as passed by the House of Representatives), August 18, 1969," stated as follows:

11. Hospitals

Present law.—Hospitals qualify for exempt status and may receive deductible charitable contributions as "charitable" organizations.

Problem.—It has been contended by some agents that hospitals (unlike educational organizations, churches, and others) must provide some significant amount of charitable services on a no cost or loss basis in order to be exempt as "charitable" organizations.

House solution.—The bill provides that hospitals are to have the same status as churches and educational institutions for purposes of tax exemption, charitable contributions, and a variety of other matters. The other requirements for exemption—no inurement of profits to private individuals, operation and organization exclusively for exempt purposes, no substantial legislative activities, and no political electioneering activities—continue to apply to hospitals.

Arguments For.—(1) These provisions are necessary to eliminate challenges to the tax-exempt status of hospitals on the ground that the hospitals are accepting insufficient numbers of patients at no charge or at rates that are substantially below cost.

(2) By establishing hospitals as a separate exempt category and removing the indefinite test of to what extent a hospital must serve those who cannot pay, this bill removes the uncertainty surrounding the hospital's continued ability to draw necessary support from the public or from private foundations to accomplish its function.

(3) Hospitals perform a useful function of the sort that deserves treatment in section 501(c)(3) on the same basis as the other organizations specifically named in that provision.

(4) The present environment of governmental assistance to permit medical care to be made available to those otherwise unable to pay, appears to make obsolete the need for hospitals themselves to subsidize the providing of medical care to poor people. This is as true regarding hospitals as it is regarding schools and churches.

Arguments against.—(1) In order to be tax exempt, hospitals historically have been required to render service to the poor whether or not there was an ability to pay for the services rendered. These provisions would do away with that requirement and many marginal income families that are now ineligible for payment of hospital care under Medicaid, and who do not have sufficient resources to pay for hospital treatment might be denied care now available to them. This is especially true in States that do not pay for hospital care of people who are eligible for general assistance under the welfare programs of the State. The bill will pose particular hardships on poor families priced out of hospital care by continually rising health costs and this will put greater pressure on Congress to expand the Medicaid program at the very time Congress is seeking to contract and moderate it.

(2) To the extent hospitals contend Medicare and Medicaid does not pay their full costs they would also contend that they are providing *charitable* services for those patients. If the bill were not changed these hospitals could refuse Medicare and Medicaid patients with impunity or could limit their services to such patients unless the Government met the hospitals' unilateral cost demands. Without the balancing effect of the present Internal Revenue Service position, government might be faced with the choice of either complying with such payment ultimatums or seeing millions of poor and aged citizens denied necessary care in community nonprofit hospitals.

(3) There is no substantial evidence that contributors to hospitals will decrease or stop their donations because the Internal Revenue Service is questioning the tax-exempt status of a hospital (or hospitals) on the ground that sufficient charitable services are not being rendered to the poor.

(4) The extent of free and "below cost" hospital care has diminished greatly with the advent of public programs such as Medicare and Medicaid. The pressure to provide free care has lessened to the extent that these multi-billion dollar programs and private hospital insurance are now paying for many of those whose bills previously went unpaid.

(5) The bill discards the charitable basis—the "community service to all" concept—on which tax exemption of hospitals is founded.

(6) If there is a legitimate complaint that Internal Revenue rulings are too vague on this point, a clarifying amendment establishing statutory standards is the appropriate remedy rather than the blanket approach of the House provision.

(7) Since the need for new legislative language has arisen because of uncertainties in administration, then the resolution of such uncertainties could be handled on an administrative basis.

The committee will recall the concern over the implications of the House-adopted provision expressed by the National Governors' Conference in the letter addressed to the chairman (reproduced below) and in subsequent correspondence. Recently in the District of Columbia indigent patients were referred by some nonprofit community hospitals to the publicly operated D.C. General Hospital because of the inability of the District government to pay more than 80 percent of outpatient hospital costs for indigent patients. This situation appears to reinforce the anxiety expressed by the National Governors' Conference. The prior rulings of the Internal Revenue Service provided a measure of protection against any unreasonable refusal by a nonprofit hospital to provide charitable and below-cost care.

NATIONAL GOVERNORS' CONFERENCE,
Washington, D.C., October 27, 1969.

Hon. RUSSELL B. LONG,
Chairman, Senate Finance Committee,
Washington, D.C.

DEAR SENATOR LONG: I understand that the Senate Finance Committee will soon be considering in Executive Session a section in the Tax Reform Act of 1969 that provides that private, non-profit hospitals can no longer be challenged to defend their tax exempt status in terms of the amount of charitable services they provide. This provision, as contained in the House passed bill, HR 13270, and in a recent Internal Revenue Service ruling, could result in hospitals refusing to serve Medicare and Medicaid patients or limiting their services to such patients unless the state meets the hospitals' demands for a certain level of payment.

I urge you, as Chairman of the Senate Finance Committee, to provide in the Tax Reform Act of 1969 for some means for states to control levels of payment to hospitals without endangering the availability of services for Medicare and Medicaid patients.

States have found it necessary to place some control on levels of payments to providers under the Medicaid program. Unless this control on the costs of Medicaid is maintained, states will be faced with an even greater financial burden under Medicaid, as will the Federal government.

Governors of states that have recent experience with freezing of levels of payment to hospitals and with challenges to the tax exempt status of hospitals will also be contacting you on this matter.

Sincerely,

CHARLES A. BYRLEY.

On the same day on which the Finance Committee deleted the House amendment, October 28, 1969, the American Hospital Association in its formal testimony on medicare before the Committee on Ways and Means included the following statement by Mr. Mark Berke, president-elect of the organization:

"The institutional health care system differs from the rest of the private sector in its philosophy toward and treatment of patients who are unable and or unwilling to pay. Other members of the private sector maintain their right to not sell their product to someone who cannot afford it or is unwilling to pay for it.

Community hospitals, because of their public responsibility, do not take such action. The right to receive service regardless of the ability to pay is extended to the entire community, and consequently the entire community has an obligation to share in these costs." [Emphasis supplied.]

Particular attention is called to the statement that "The right to receive service regardless of the ability to pay is extended to the entire community . . ." If the testimony of the American Hospital Association before the Committee on Ways and Means is a fair and accurate presentation of the hospitals' position, the staff is at a loss to understand why the hospitals sought the House amendment in the first instance.

Furthermore, the staff cannot reconcile that statement of dedication to the poor with the example of a tax-exempt hospital included in Revenue Ruling 69-545:

"Hospital A is a 250-bed community hospital. Its board of trustees is composed of prominent citizens in the com-

munity. . . . The hospital operates a full-time emergency room and no one requiring emergency care is denied treatment. *The hospital otherwise ordinarily limits admissions to those who can pay the cost of their hospitalization. . . . Patients who cannot meet the financial requirements for admission are ordinarily referred to another hospital in the community which does serve indigent patients.*

The hospital usually ends each year with an excess of operating receipts over operating disbursements from its hospital operations. Excess funds are generally applied to expansion and replacement of existing facilities and equipment, amortization of indebtedness, improvement in patient care, and medical training, education, and research." (Emphasis supplied.)

In the Internal Revenue Service example of what it proposes to recognize as a tax-exempt hospital, "The right to receive service regardless of the ability to pay" is clearly *not* extended to the entire community.

The staff strongly recommends revocation of Revenue Ruling 69-545 in light of the recent legislative history and continuation of the prior position of the Service until such time as Congress can devise an alternative approach establishing reasonable yardsticks of charitable service related to the financial capacity of a hospital. Such action by the Service would assist in protecting the availability of necessary hospital care to Medicare, Medicaid, and other poor patients.

CHAPTER FIVE

PAYMENT FOR PHYSICIANS' SERVICES

Statutory Limitations on "Reasonable Charges"

The medicare statute and committee reports reflect congressional concern that payments to physicians under part B of title XVIII be equitable not only from the standpoint of the physician but also from the standpoint of the Government and the beneficiaries it represents—beneficiaries from whose funds come one-half of the costs of part B.

That concern with mutual equity finds statutory expression in section 1842(b)(3)(B) which requires the part B carrier to—

* * * assure that, where payment * * * is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, * * *

At the conclusion of the paragraph, the statute instructs that:

In determining the reasonable charge * * * there shall be taken into consideration the customary charges for similar services * * * as well as the prevailing charges in the locality for similar services.

With respect to the first provision, it seems clear that Congress intended that a carrier, for example a Blue Shield Plan, should not allow as a reasonable charge that portion of a doctor's bill which was higher than what Blue Shield would ordinarily consider appropriate to cover for the same service rendered to one of its own subscribers.

In determining the "reasonable charge" the statute provides that "customary and prevailing" charges for various services shall be taken into consideration in determining the reasonable charge. But, while stating that customary and prevailing charges shall be *considered*—the statute did not require that those factors should be the only elements determining final payment. This understanding of the statute was reflected by the Commissioner of Social Security at a meeting held at the Department of Health, Education, and Welfare in December, 1968 to consider whether the \$4 monthly premium rate should be continued during fiscal 1970. He stated then that the statute required only "consideration" of customary and prevailing medical charges—it did not mandate payment on that basis.

The level of customary charges and of prevailing charges are factors which enter only into the determination of "reasonable" charge. Under the statute the reasonable charge, so determined, should not be payable (in effect, it would be unreasonable) if it exceeded the amount which the carrier ordinarily paid under comparable circumstances for its own subscribers or policyholders.

1965: Blue Shield Testifies on Its Knowledge of Customary and Prevailing Charges

On May 6, 1965, the National Association of Blue Shield Plans testified before the Finance Committee on the then-pending medicare

legislation. In that portion of their testimony urging that the Government make full use of Blue Shield Plans as part B carriers, the association reported to the committee:

* * * because of Blue Shield's close relationships with participating physicians and local professional societies, our plans have established effective patterns for determining prevailing charges, for assuring patients of predictable benefits, and for controlling utilization practices * * *

Blue Shield continued, stating:

In formulating payment schedules, Blue Shield plans customarily request information from local physicians as to prevailing charges in the community. * * * Accordingly, because of its relationship with local physicians and their professional societies, Blue Shield enjoys unique advantages in terms of built-in controls of utilization and of fee levels. (Emphasis supplied) ¹

In material supplied to the committee supplementing their oral testimony the National Association of Blue Shield Plans advised the committee that:

* * * even in "indemnity plan areas" the Blue Shield schedules generally reflect the prevailing charges in the community. Therefore, (including service benefit plans) an *increasing percentage of claims are satisfied in full by the Blue Shield payment*. As you know, there is a *growing tendency among physicians throughout the country to stabilize their fee schedules and to accept the same fee for similar service from all patients regardless of income* * * * (Emphasis supplied)²

This testimony of the National Association of Blue Shield plans as to the currency and adequacy of Blue Shield benefit schedules motivated the committee to include the following language on page 44 of its report to the Senate on the Social Security Amendments of 1965:

And, where service benefit plans, for payment for physicians' services, serve as carriers under the program, the use of the same agreed-upon fee schedules that are employed in their own programs may be helpful in avoiding the possibility of disputes regarding fees.

Reasonable Charges Under Medicare

Most Blue Shield plans are service benefit plans. The majority of the part B carriers are Blue Shield plans. Yet those same agreed-upon fee schedules that are most generally employed in their own programs and which Blue Shield told the Congress generally reflect the prevailing charges in the community have seldom been applied to restrain the maximum charges allowable under part B of medicare.

Medicare Payments are Usually Significantly Higher Than Blue Shield's

Unfortunately medicare carriers have never been advised to limit medicare payments to the amount they pay for their own subscribers. Medicare administrators, apparently feeling that fee schedules would be "inappropriate" for the program, took the position that the limitation applied *only* if a carrier offered a policy of its own which paid doctors *solely* on the basis of "customary and prevailing" charges. The fee schedules used as the basis of payment for millions of subscribers in New York City for example, were considered inapplicable to medicare. But if the New York plan had a customary and prevailing contract which covered only 1,000 high income subscribers then that level of payment—and only that—became the limit for millions

¹ Social Security Hearings, H.R. 6675, Committee on Finance, Part 1, p. 395.

² Op. cit., pp. 528-535.

of low-income medicare beneficiaries. In view of the fact that prior to medicare virtually no Blue Shield plan or insurance company offered basic surgical-medical insurance making payments on the basis of customary and prevailing charges, the statutory limitation was virtually nullified.

The effects of not applying this limitation is readily apparent from chart 1. The chart is based upon information provided to the staff by Blue Shield and the Bureau of Health Insurance. It compares the average medicare charge approved by the medicare carrier in each carrier area for 8 surgical procedures frequently performed on older people with the maximum amounts Blue Shield pays for those same services under its most widely held contracts in the areas. The chart indicates medicare payments are usually significantly higher than Blue Shield payments.

Despite the legislative history—including the specific reference in the committee reports to use of fee schedules employed by “service benefit plans”—a Social Security policy statement in 1966 maintained that “fee schedules, dual or otherwise, would be inappropriate for the program.”

Social Security Administration Permits Carriers to Pay More Under Medicare Than Under Their Own Plans

The following statement was made in early 1966 by the then Director of the Bureau of Health Insurance, Mr. Arthur Hess, on how medicare's policymakers arrived at their position for the determination of “reasonable charges:”

“The determination of reasonable charges involves a wide range of difficult issues.

“As passed by the House of Representatives, the provisions governing the determination of charges required that the charge ‘be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier.’ The report of the Committee on Ways and Means of the House of Representatives included the following statement with respect to these provisions: ‘In determining reasonable charges, the carriers would consider the customary charges for similar services generally made by the physician or other person or organization furnishing the covered services, and also the prevailing charges in the locality for similar services.’ The Senate included a similar statement in the bill itself, and this statement is included in the law as enacted. There is then, no question about the intent of Congress that the determination of reasonable charges *would be based on the customary charges of the physician and the prevailing charges in the locality.*

“When we consulted with the work group on physician participation, which included representatives of carriers and medical organizations, concerning the development of guidelines for part B intermediaries, we were advised that the carriers and the physicians had considerable experience in dealing with the concepts involved. *Representatives of Blue Shield assured us that, while the fee schedule approach was predominant under Blue Shield plans, many plans had developed the necessary experience through the analysis of bills and dealings with medical societies.*” (Emphasis supplied.)

Chart 1.—Comparison of Medicare and Blue Shield allowances for selected surgical procedures

Medicare Carrier	Excision of lens (cataract operation)		Electrocoagulation prostate		Inguinal hernia repair		Cholecystectomy (gall bladder)		Prostatectomy		Hemorrhoidectomy		Bronchoscopy		Radical mastectomy		Medicare Carrier
	Average medicare reason- able charge ¹	Blue Shield maximum payment ³	Average medicare reason- able charge ¹	Blue Shield maximum payment ³	Average medicare reason- able charge ¹	Blue Shield maximum payment ³	Average medicare reason- able charge ¹	Blue Shield maximum payment ³	Average medicare reason- able charge ¹	Blue Shield maximum payment ³	Average medicare reason- able charge ²	Blue Shield maximum payment ³	Average medicare reason- able charge ²	Blue Shield maximum payment ³	Average medicare reason- able charge ²	Blue Shield maximum payment ³	
Alabama Blue Shield.....	\$345	\$75	\$371	\$75	\$193	\$75	\$303	\$100	\$381	\$125	\$131	\$50	\$78	\$35	\$305	\$150	Alabama Blue Shield.
Arizona (Aetna).....	419	276	419	276	240	121	340	207	388	276	125	104	95	69	433	242	Arizona (Aetna).
Arkansas Blue Shield.....	293	210	363	210	235	90	300	165	375	210	180	75	75	45	277	180	Arkansas Blue Shield.
California Blue Shield.....	492	492	510	492	240	238	367	NA	553	NA	179	NA	84	NA	408	NA	California Blue Shield.
California (Occidental Life).....	531	492	575	492	275	238	435	NA	592	NA	209	NA	105	NA	436	NA	California (Occidental Life).
Colorado Blue Shield.....	348	250	336	250	165	125	320	250	333	250	101	100	69	50	350	275	Colorado Blue Shield.
Connecticut General Life.....	419	300	380	250	214	150	340	250	388	275	166	110	94	60	345	250	Connecticut General Life.
Delaware Blue Shield.....	350	254	400	259	175	150	250	225	² 289	267	200	104	67	63	368	271	Delaware Blue Shield.
Florida Blue Shield.....	426	233	468	233	255	117	385	233	² 469	233	149	100	82	50	385	233	Florida Blue Shield.
Georgia (John Hancock).....	349	175	380	175	180	100	421	¹² 163	356	¹² 163	115	¹² 78	93	¹² 46	360	¹² 163	Georgia (John Hancock).
Hawaii (Aetna).....	403	(¹¹)	² 350	(¹¹)	205	(¹¹)	² 337	(¹¹)	² 413	(¹¹)	150	(¹¹)	NA	(¹¹)	350	(¹¹)	Hawaii (Aetna).
Idaho (Equitable).....	317	358	359	330	202	165	318	281	400	330	NA	138	NA	83	NA	303	Idaho (Equitable).
Illinois Blue Shield.....	444	165	493	165	305	100	417	165	625	165	168	65	95	65	367	165	Illinois Blue Shield.
Illinois (Continental Casualty).....	367	165	317	165	200	100	294	165	361	165	143	65	83	65	296	165	Illinois (Continental Casualty).
Indiana Blue Shield.....	356 {	⁵ 400 ⁶ 350	341 {	⁵ 400 ⁶ 350	172 {	⁵ 200 ⁶ 175	273	NA	357	NA	131	NA	67	NA	278	NA	Indiana Blue Shield.
Iowa Blue Shield.....	341	180	375	180	165	90	² 236	150	² 325	180	108	60	75	45	200	150	Iowa Blue Shield.
Kansas Blue Shield.....	301	40 ⁴	344	400	189	200	263	(¹¹)	313	(¹¹)	140	(¹¹)	88	(¹¹)	314	(¹¹)	Kansas Blue Shield.
Kentucky (Metropolitan).....	318	240	345	255	185	140	313	225	371	255	116	105	86	58	317	245	Kentucky (Metropolitan).
Louisiana (Pan-American Life).....	379 {	⁹ 150 ¹⁰ 125	333	150	202 {	⁹ 113 ¹⁰ 75	317	NA	² 256	NA	117	NA	78	NA	216	NA	Louisiana (Pan-American Life).
Maine (Union Mutual).....	325	175	324	175	175	100	233	138	317	175	175	75	71	38	225	163	Maine (Union Mutual).
Maryland Blue Shield.....	367	200	376	225	241	150	300	200	400	225	158	115	82	50	281	275	Maryland Blue Shield.
Massachusetts Blue Shield.....	393	225	349	200	207	125	291	225	357	225	67	100	70	50	330	250	Massachusetts Blue Shield.
Michigan Blue Shield.....	370	315	362	315	188	135	271	248	355	315	96	90	73	68	288	270	Michigan Blue Shield.
Minnesota Blue Shield.....	341	300	322	300	197	131	259	225	300	300	175	113	75	75	213	263	Minnesota Blue Shield.
Mississippi (Travelers).....	(⁷)	² 188	(⁷)	191	(⁷)	150	(⁷)	169	(⁷)	191	(⁷)	79	(⁷)	55	(⁷)	150	Mississippi (Travelers).
Missouri Blue Shield.....	345	300	325	300	² 193	150	350	250	350	300	157	150	67	75	325	300	Missouri Blue Shield.
Missouri (General American Life).....	418	100	334	150	206	75	311	125	406	150	142	50	74	35	355	125	Missouri (General American Life).
Montana Blue Shield.....	334	293	330	270	169	158	288	270	375	270	150	135	75	77	350	315	Montana Blue Shield.
Nevada (Aetna).....	565	NA	600	NA	315	NA	450	NA	² 440	NA	158	NA	100	NA	NA	NA	Nevada (Aetna).
Nebraska (Mutual of Omaha).....	¹³ 303	275	¹³ 347	300	¹³ 168	150	¹³ 270	250	¹³ 379	300	¹³ 127	75	¹³ 69	75	¹³ 202	275	Nebraska (Mutual of Omaha).
New Hampshire/Vermont Blue Shield.....	345	180	392	185	191	100	300	160	426	185	103	75	60	40	292	175	New Hampshire/Vermont Blue Shield.
New Jersey (Prudential).....	437	275	447	300	235	150	361	250	501	300	149	100	88	70	400	275	New Jersey (Prudential).
New Mexico (Equitable).....	383	(¹¹)	385	(¹¹)	199	(¹¹)	340	(¹¹)	NA	(¹¹)	NA	(¹¹)	NA	(¹¹)	NA	(¹¹)	New Mexico (Equitable).
New York Blue Shield (Western New York).....	383	275	400	300	178	125	291	225	400	300	132	150	92	75	275	350	New York Blue Shield (Western New York).
New York Blue Shield (United Medical).....	490	275	456	300	243	150	366	225	569	300	136	120	110	90	428	275	New York Blue Shield (United Medical).
New York Blue Shield (Genessee Valley).....	373	375	365	365	184	165	275	275	365	365	97	150	62	75	328	365	New York Blue Shield (Genessee Valley).
New York (Group Health Insurance).....	526	275	² 303	300	286	150	² 274	225	400	300	222	120	111	90	376	275	New York (Group Health Insurance).
New York (Metropolitan).....	371	252	367	240	203	141	311	¹² 209	403	¹² 253	126	¹² 112	86	¹² 71	290	¹² 242	New York (Metropolitan).
North Carolina (Pilot Life).....	340	155	373	150	213	75	289	150	403	150	158	60	73	35	275	125	North Carolina (Pilot Life).
North Dakota Blue Shield.....	353	375	370	400	167	¹¹ 375	294	(¹¹)	375	(¹¹)	60	(¹¹)	68	(¹¹)	275	(¹¹)	North Dakota Blue Shield.
Ohio (Cleveland Blue Shield).....	393	315	314	350	190	150	350	250	367	350	148	115	81	75	254	300	Ohio (Cleveland Blue Shield).
Ohio (Nationwide).....	350	150	329	200	202	100	268	175	396	250	160	100	78	50	346	200	Ohio (Nationwide).
Oklahoma (Aetna).....	346	250	350	255	184	140	287	225	388	255	121	110	83	60	431	245	Oklahoma (Aetna).
Oregon and Alaska (Aetna).....	416	NA	395	NA	201	(⁷)	353	NA	400	NA	150	NA	70	NA	306	NA	Oregon and Alaska (Aetna).
Pennsylvania Blue Shield.....	330	270	334	270	192	150	281	270	365	270	123	120	75	66	281	240	Pennsylvania Blue Shield.
Rhode Island Blue Shield.....	394	254	400	259	225	150	375	225	² 335	267	195	104	83	63	297	271	Rhode Island Blue Shield.
South Carolina Blue Shield.....	364	230	356	230	188	135	260	200	300	240	137	95	91	55	300	245	South Carolina Blue Shield.
South Dakota Blue Shield.....	375	(⁸)	357	(⁸)	147	(⁸)	300	(⁸)	360	(⁸)	145	(⁸)	90	(⁸)	NA	(⁸)	South Dakota Blue Shield.
Tennessee (Equitable).....	351	210	336	210	195	115	263	165	405	210	162	90	86	45	344	180	Tennessee (Equitable).
Texas Blue Shield.....	358	220	351	225	188	130	303	95	352	235	158	90	86	55	353	235	Texas Blue Shield.
Utah Blue Shield.....	309	270	386	225	188	158	² 227	225	² 350	225	120	113	78	77	275	315	Utah Blue Shield.
Virginia.....	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	(⁷)	Virginia.
Washington Blue Shield.....	382	347	392	¹² 331	182	¹² 157	309	¹² 267	390	¹² 332	164	¹² 123	74	¹² 84	318	¹² 335	Washington Blue Shield.
West Virginia (Nationwide).....	329	¹² 206	282	¹² 211	172	¹² 125	258	¹² 189	350	¹² 226	89	¹² 90	68	¹² 85	275	¹² 222	West Virginia (Nationwide).
Wisconsin (Milwaukee Blue Shield).....	395	(¹¹)	400	(¹¹)	² 174	(¹¹)	275	(¹¹)	² 317	(¹¹)	175	(¹¹)	75	(¹¹)	330	(¹¹)	Wisconsin (Milwaukee Blue Shield).
Wisconsin (Madison Blue Shield).....	357	(¹¹)	327	(¹¹)	174	(¹¹)	271	(¹¹)	320	(¹¹)	92	(¹¹)	68	(¹¹)	213	(¹¹)	Wisconsin (Madison Blue Shield).
Wyoming (Equitable).....	350	250	350	250	NA	150	² 250	200	NA	250	NA	125	NA	60	NA	250	Wyoming (Equitable).
District of Columbia Blue Shield.....	437	259	312	264	233	153	356	230	428	272	175	106	91	64	405	276	District of Columbia Blue Shield.
Puerto Rico Blue Shield.....	400	NA	400	NA	199	NA	300	NA	400	NA	133	NA	93	NA	420	NA	Puerto Rico Blue Shield.

¹ Before coinsurance of 20 percent for services rendered January-June 1968.

² Services rendered between July 1, 1966 and June 30, 1967.

³ Maximum allowance under fee schedule (or other basis of payment if no fee schedule) of most widely held Blue Shield contract in same geographical area. (If more than one plan is in the same area, figure shown is average allowance under the plans.)

⁴ Less than 25 cases reported.

⁵ City.

⁶ Rural.

⁷ Not available (included with other areas, not separated by State).

⁸ Schedule plus 75 percent of difference.

⁹ Blue Cross Plan.

¹⁰ Blue Cross Plan.

¹¹ Usual and customary fees to participating physicians.

¹² Average of allowances for 2 or more plans in State.

¹³ Includes figures for another area for which carrier is also responsible.

NA: Not available.

Note.—It is possible that under Medicare additional bills were also submitted for routine post-operative visits and services. Such visits and services are typically included in the Blue Shield surgical allowance and no additional payments are allowed. Thus, the average Medicare payment may be somewhat understated in comparison with the Blue Shield allowance.

Sources: National Association of Blue Shield Plans and the Social Security Administration.

This statement was in essence the policy adopted by the Social Security Administration as the basis for payment of physicians under part B of medicare.

It is the opinion of the staff that the premises underlying that policy are contrary to the congressional intent and that the erroneous policy itself is an important cause of the enormous inflation in costs of the part B program. This policy had the effect of “* * * turning an expected ceiling on fees into a floor.”³

The statute requires only that *consideration* be given to customary and prevailing charges. The term “consideration” does not in our opinion indicate congressional mandate that reasonable charges would be “based” only upon customary and prevailing charges. We believe the clearer interpretation of the statute leaves little doubt that medicare reimbursement for doctors’ services was to be based upon “reasonable charges” and that in determining what was reasonable the administrator was given discretion to look to customary and prevailing charges so long as the ultimate amount determined did not exceed the amount the carrier itself ordinarily allowed for comparable services.

Congressional Limitations and Controls Abandoned by Social Security Administration at Cost of Hundreds of Millions of Dollars

The extensive testimony by the National Association of Blue Shield Plans before the committee in 1965 as to Blue Shield’s built-in controls of utilization and fee levels was relied upon both in the statute and committee report. The claim by the Nation’s largest medical insurer that even in indemnity plan areas the Blue Shield schedules generally reflect the prevailing charges in the community indicated to the Congress that reasonable limitations upon medicare payments based upon community norms were widely available and generally operative. As the chart comparing Blue Shield and medicare payments reveals, medicare payments do not mirror Blue Shield’s reflection of prevailing fees—medicare presents a distorted, much magnified, and expensive image all its own.

Those congressional assumptions as to the availability and application of reasonable controls on medical fees appear to have been forgotten almost as soon as medicare was enacted. Limitations and controls are provided for, as we read the statute and the Finance Committee report, but they appear to have been treated as but abstract and minor impediments to what has become a very real and very costly policy of laissez-faire with respect to physicians’ fees under medicare.

No one can say for certain how much money has been overpaid as a result of the failure to apply the statutory limitation on “reasonable charges.” Compared with Blue Shield payments for similar services under their most widely held contracts, however, it is safe to say that medicare has spent many hundreds of millions of dollars more than would otherwise have been required had those same Blue Shield schedules served to limit reimbursement.

³ Address by Representative Durward G. Hall before American College of Hospital Administrators, April 30, 1969. Congressional Record, pp. E3622-23, May 5, 1969

Agreed-upon Fee Schedules of Service Benefit Plans Contain Built-in Limitation on Fee Escalation

As has been noted the committee reports in 1965 made specific reference to the use in medicare of the same "agreed-upon fee schedules that are employed in their own programs" by service benefit plans. An agreed-upon fee schedule does not encompass so-called customary and prevailing or usual and customary contracts. The latter provides a scale for determining payments which, in the main, depends upon an individual physician's billing practices limited to a prevailing maximum. The physician is free at periodic intervals to increase his customary charges and if his action is followed by sufficient other doctors, an increase in the prevailing limitation would result. In other words, the "customary and prevailing" contract is a dynamic type of coverage characterized by increased and increasing payments.

The agreed-upon fee schedule, on the other hand, is a static, fixed basis of payment. Until such time as the entire fee schedule is reviewed and revised upward (which usually requires the approval of State insurance departments), the amounts payable are predictable and known to all. Both the patient and the physician know in advance exactly how much Blue Shield or other health insurers will allow for a given service or procedure.

It was to these well-known and predictable yardsticks—Blue Shield fee schedules—that we believe the committee reports refer.

A service benefit plan is one where participating physicians have agreed to accept the plan's allowance as full payment in those cases where the subscribers' income is below the maximum specified in the subscriber's contract. Where the patient's income exceeds the maximum, as is frequently the case, or where care is provided by a nonparticipating physician, the Blue Shield allowance is still the same agreed-upon fee specified in the schedule but the physician is not obligated to accept it as full payment.

"Means Test" Argument a Red Herring

Social security, ignoring the reference in the committee reports to use of such fee schedules, instructed Blue Shield carriers not to use the fee schedules in their service benefit contracts as limitations on amounts payable to doctors providing care to medicare beneficiaries. Further, Social Security instructed Blue Shield carriers to disregard the millions of bills submitted for payment under those fee schedules in their determination of customary and prevailing charges for medicare. The reasoning was that service benefit plans use "means tests" and that such tests were not intended by medicare.

We believe such a rationale is illogical.

The point here is that a Blue Shield subscriber—regardless of whether his income is below or above the service benefit level—is entitled to have precisely the same dollar allowance paid by Blue Shield for the service rendered him.

Many Blue Shield subscribers hold contracts containing service benefit income limits for which they cannot qualify. But, in every case they are entitled to payment of the amounts specified in the fee schedule—which is no greater and no less than that payable for another subscriber holding the same contract and whose income is below the maximum specified in the contract. And, as is not infrequently the case, where care is provided by a nonparticipating phy-

sician, the Blue Shield allowance is still the same amount specified in the fee schedule and the service income limits are irrelevant. In other words, *the amount payable by the service benefit plan is fixed and identical for all subscribers receiving a given medical procedure or service. There is no means test applied to determine whether the plan will pay or in what amount.* The third-party payer—Blue Shield—has a fixed and identical dollar liability to each and every subscriber under a given contract—regardless of his income.

Social Security Administration Twists Meaning of Statutory Limitation, Negating Its Effect

The Social Security Administration took an explicit statutory limitation on the maximum physician's charge which could be recognized as "reasonable" for purposes of medicare payment and through fallacious logic turned it into a complex nullity. The "comparable circumstances" phrase in the statute was interpreted as constituting a limitation *only* if a carrier had a policy or contract which paid benefits on a so-called "customary and prevailing" basis. As has been pointed out, virtually none of the Blue Shield plans had such contracts generally available during the years of debate on medicare or at the time of medicare's consideration and enactment, or on the effective date of medicare. Thus, Social Security called for application of a phantom yardstick.

Blue Shield itself has no illusions concerning the term "comparable circumstances." In October, 1968, a new membership standard was adopted by the Blue Shield plans. Plans were required to "** * * make available a paid-in-full program, based upon the usual, customary and reasonable charges of physicians and which takes into consideration the pattern of charges for similar services provided under comparable circumstances in the same geographical area.*" (Emphasis supplied.)

The italicized portion of the Blue Shield standard is virtually identical with that of the medicare statute. Yet, Blue Shield, the Nation's largest medical insurer, as well as the predominant medicare carrier, understands that the term "comparable circumstances" does not mean what Social Security arbitrarily determined it meant.

Here is what that term means to Blue Shield (as well as what the staff believes "comparable circumstances" meant to the Congress in 1965): "*Comparable circumstances refers to the medical and site circumstances involved in the provision of services.*"⁴

The failure to apply a similar logical interpretation under the Federal program is responsible, in our opinion, for much of the inflation in the costs of Part B of medicare.

The point at issue is the statutory restraint that a physician's charge, in order to be considered "reasonable" be "not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier."

The plain meaning of that provision is that a Blue Shield plan, serving as a medicare carrier, would not allow more as a medicare charge than it ordinarily allowed under its regular basic surgical-medical contract for its own subscribers. The limitation could have been applied on the benefits allowed under the plan's most widely-held contract or even the average payments actually made under all of the plan's different types of basic contracts. Additionally, allowances

⁴ Statement supplied to the staff by National Association of Blue Shield Plans.

could have been calculated using a relative value scale for those services covered by medicare but not by the particular Blue Shield carrier.

Such limitations upon "reasonable charges," were, we believe, intended by the Congress as a sensible control which could have been determined with reasonable objectivity.

Future Impact of Past Policies

We have indicated the enormous increased costs in part B because of the failure to apply effective controls and limits on "customary and prevailing" physician charges. The question may be asked as to what future costs will be in the absence of changes in the present method of payment under part B.

Recently, the Civil Service Commission contracted with a private actuarial consulting firm to evaluate the Federal Employee Health Benefits Program. Included in the report to the Commission were comments on the effectiveness of controls on utilization of benefits and costs. Their comments are relevant because the majority of the Federal employee basic surgical-medical coverages have shifted to a "usual and customary" "or customary and prevailing" basis of payment for physicians' services since the advent of medicare. The prognosis with respect to future costs of "usual and customary" benefits is not good. The analogy to medicare is apparent in the following comments from the report:

"Controls on utilization of benefits hinge upon the descriptive limitation of the type of coverages that are offered as well as on the deductible and coinsurance provisions (indemnity plan). By this is meant that standard coverages, described in a conventional way, with reasonable limitations can be processed satisfactorily by the trained claims paying personnel of each governmentwide carrier. *A notable exception is with respect to a "usual and customary" payment basis whether it applies to doctors' fees or other services. In fact, we feel that significantly higher payments for doctors' services are yet to come.* * * *

"A health care plan which is * * * *reimbursing high percentages of usual and customary fees is particularly subject to inflation.* Thus stringent enough controls to hold down premiums cannot reasonably be expected." (Emphasis supplied.)

Rush To Develop Data on "Customary and Prevailing" Charges

We believe the congressional objective of establishing a limit on medicare payments to doctors based upon existing fee schedules was lost when carriers were instructed by Social Security not to use their regular fee schedules as medicare maximums unless those contracts paid benefits on the basis of "customary and prevailing" charges.

The general lack of adequate and significant "customary and prevailing" data during medicare's initial and crucial "tooling-up" period was when benchmarks were established for payments to physicians. Subsequent upward changes in fees all relate back to those insubstantial baseline data.

Responses to staff questions concerning the precise methods employed by each carrier in determining "customary and prevailing" physician charges at the outset of medicare indicate that the foundation for payment of physicians was and is quite shaky and of dubious validity.⁵

Physicians Asked to Furnish Data on Their "Customary" Charges

A fair number of carriers resorted to surveys of physicians in order to establish a basis for payment of customary and prevailing fees. Many other carriers refused to undertake such surveys because, in the words of one of them "A fee survey was considered unwise because it was felt that it would produce 'anticipatory bias' [on the part of physicians responding to the survey] which would tend to be inflationary." Another large Blue Shield plan said that "* * * some 'anticipatory bias' existed within medical circles which would render invalid any questionnaire survey directed at obtaining the usual charge of an individual physician."

To the extent that medicare payments are based and built upon the results of those surveys the "anticipatory bias" incorporated into the results has now become "realized bias." This is another costly consequence, in our opinion, of the failure to provide carriers with uniform guidelines as to how and how not to assemble charges data at the inception of medicare.

Many carriers based their determination of physicians' customary and prevailing charges solely upon billings to medicare beneficiaries after the program began. A number of carriers still construct their physician profiles from limited medicare charges data. It is extremely difficult for us to understand how, in these cases, those carriers can accurately determine that a physician's charges to his aged patients represent his customary charges to all patients. We submit that they cannot make a valid determination where the determination of customary and prevailing is limited to medicare data only. Again, this is another important control point to which little administrative pressure has been applied. We believe the situation can be improved by requiring carriers to incorporate all charges data—medicare and nonmedicare.

Utah Blue Shield Plan Sets Good Example

We would be remiss if in the course of criticizing the methods of payment employed in the administration of medicare we did not point out that one carrier, the Utah Blue Shield Plan, as it explains its approach, appears to fulfill what the staff believes the medicare legislation intended.

The Utah Blue Shield Plan used all of the payments made in its regular nonmedicare business as the basic data source for medicare. The plan said it had undertaken a confidential survey of physicians prior to July 1, 1966 but the limited response of physicians (approximately 50 percent) "diminished the credibility of the data collected to such an extent that only historical claims data in our files was used in determining customary and prevailing charges."

Most importantly, the plan told us:

"We are a Blue Shield service benefit plan and have limited the reasonable charge to medicare beneficiaries to no more than

⁵ Five of the questions asked by the staff with respect to carrier capacity to determine "customary and prevailing" physician charges appear in Appendix E, p. 253 along with some pertinent replies from carriers.

we allow for our subscribers under our basic surgical-medical contracts which provide for service benefits.

"In so doing, we used the schedule of benefits under our most widely-held contract. [That contract is a fixed-fee schedule.]

"* * * during the period October, 1967 to June, 1968, 8,667 claims were reduced solely pursuant to section 1842 (b)(3)(B) of the Social Security Act. \$199,754.39 was the total amount of such reductions and the average reduction was \$23.04."

Staff Recommendations

The staff believes that the existing interpretation of the part B statutory limitation is erroneous and not consistent with the congressional intent. We recognize, however, that the interpretation has been applied for more than 3 years; thus the first suggestion offered below is intended as a stopgap measure. As a permanent solution we think the provisions concerning reimbursement of physicians should be rewritten in the statutes. With that thought in mind, the staff has developed a basis for comprehensive revision which is outlined in the second recommendation below.

Recommendation for Reasonable Limit on "Reasonable Charges"

To conform present medicare practice to the congressional intent expressed in the statute and contemporaneous committee reports and if no substantive changes are made in part B, the staff recommends that all Blue Shield plans serving as medicare carriers be required to limit the physician's charge recognized as "reasonable" to not more than the average payment actually made for a given service or procedure under all of its basic surgical-medical subscriber contracts during a reasonably recent prior period of time. Thus, for example, if Blue Shield in Massachusetts under all of its various subscriber contracts actually paid an average of \$250 for removal of cataract (excision of lens) during 1968, medicare would not recognize charges above \$250 as "reasonable" for purposes of reimbursement.

For those services which medicare covers but which Blue Shield does not, maximum allowances could be calculated on a basis relative to the average actual payments which Blue Shield made on the services it does cover.

Additionally, to avoid, at least to some extent, costly and often medically unnecessary "gang visiting," amounts allowed should be reduced for multiple visits, on the same day to patients in the same facility. Similarly, limitation on amounts allowed for "injections" and routine laboratory tests should be established and applied.

Fee Schedules: Recommendation for a Part B Program With Built-in Cost Limitations

We have developed a basis for possible revision of part B of medicare, in large part based upon customary insurance practices in the private sector, which the committee might consider as a mechanism to substantially simplify administration and control costs.

1. An advisory board of actuaries and underwriters would be selected by the Secretary of Health, Education, and Welfare from private health insurance companies to assist in developing a schedule of fixed indemnity allowances for surgical and medical care for each of the nine census regions in the Nation (in recognition of geographic variation in charges for similar medical services). The allowances for any given region should not be more than 10 (or possibly 15) percent greater than the average for all other census regions combined. Appropriate provision should also be made so that prepaid group practice and similar programs can provide care and be reimbursed on other than a fee-for-service basis.

2. The advisers would recommend specific maximum amounts allowable for covered services based upon a total monthly premium of \$8 per beneficiary—the amount now paid—after allocating a sufficient portion of the premium for reserves and administrative costs.

3. The \$50 deductible now in part B would apply only to charges for services rendered by non-participating physicians.

4. Payments would be made on the basis of 80 percent of the maximum amount allowable specified in the benefits schedule or 80 percent of the actual charge, whichever was less.

5. A participating physician would be one who agrees to accept up to the scheduled allowance as his full charge for the services he renders to all medicare beneficiaries. In the case of a participating physician payments would be made directly to him by medicare. He would collect 20 percent of the scheduled amount from the beneficiary. Alternatively, a co-pay approach might be employed. For example, the beneficiary could pay out of pocket the first \$2 or \$3 of the charge for home and office visits.

6. Where a doctor did not elect to become a participating physician, all payments due from medicare to beneficiaries for services rendered by him would be made directly to those beneficiaries on the basis of a receipted or non-receipted bill.

7. A physician could, upon appropriate notice, elect, or withdraw from, status as a participating physician.

8. The \$8 monthly premium rate would be fixed by law and could not be changed except by legislative action.

9. In case the premium and reserves were inadequate to fully meet the obligations of the program in a given year, the advisory board would be expected to adjust the scheduled allowances downward so as to make up the deficit in the following year or years. Such revisions could be made applicable only to those regions experiencing abnormal utilization or could be made applicable nationally.

We believe this method of reimbursement offers the following advantages:

1. Simplified administration and reduced administrative costs.
2. Anti-inflationary structure.
3. Self-adjusting to the funds available.
4. Predictability of allowances and payments.
5. Strong parallel and relationship to basic medical-surgical insurance policies now sold by private health insurers.
6. Avoidance of Federal determination as to whether a physician's charges are reasonable.

7. Functions within traditional framework of the medical insurance obligation of an insurer (social security) to the insured (beneficiary) whereby specified indemnities are payable to the insured by the insurer when he has incurred a legal obligation to pay a physician who has rendered care covered under the policy. The obligation to pay here, as with all private health insurance, flows from the insurer to the insured (and not from the insurer to the physician or other provider).

8. Beneficiary understanding enhanced, and \$50 deductible eliminated where services are provided by participating physicians.

9. Physician has freedom of choice whether to become a participating physician. That choice may be changed upon reasonable notice.

10. The Government will not tell the nonparticipating doctor how much to bill the medicare beneficiary and it will not interfere with his privilege of collecting his own bills. The Government would pay its scheduled allowance to the beneficiary directly on the basis of a receipted or nonreceipted bill for covered services. That would fulfill medicare's financial obligation as insurer to the beneficiary. The question of what the patient does with the money after he has been paid by medicare would not be subject to governmental intervention—that would remain a private aspect of the doctor-patient relationship.

Recommendation for Uniform Definitions of Medical Procedures

To avoid fragmentation of fees the staff recommends that uniform definitions of medical procedures and services be applied in the payment of benefits under part B.

Adoption of uniform definitions would avoid situations such as that where a surgeon charges one fee for the actual surgery and then charges additional separate fees for normal preoperative and postoperative visits. Most Blue Shield plans allow a single inclusive fee covering the preoperative and postoperative care ordinarily and routinely provided in conjunction with the surgery itself.

Appropriate definitions can be obtained from Blue Shield and others.

CHAPTER SIX

PAYMENTS TO "SUPERVISORY" PHYSICIANS IN TEACHING HOSPITALS

The Problem

A major and costly problem has arisen in medicare with respect to payment for the services of so-called "supervisory physicians" in teaching hospitals. Such services may currently involve medicare payments of \$100 million or more annually.

The hospitals concerned are those with approved programs of training for interns and residents. Such hospitals are usually affiliated with or operated by medical schools. The training of interns and residents involves, in large part, the rendering of direct patient care—particularly in the case of service patients (also called institutional patients)—under the supervision, and to varying extents the personal assistance in such care, of qualified teaching physicians. In the case of an institutional patient, the supervisory physician is generally designated by the hospital as that patient's attending physician upon admission of the patient to the hospital.

The institutional patient may be an individual who was referred to the hospital by a physician who was not a member of that hospital's staff; he may have been recommended as an inpatient by a physician in the hospital's outpatient department; he may have been admitted to the hospital in an emergency situation; or he may have presented himself and had his admission to the hospital approved by a member of the hospital's house staff.

The institutional patient is in contrast with the private patient. The latter generally has his own private doctor—usually a member of the hospital's medical staff, whom he visited and consulted with outside of the hospital setting; who subsequently arranged for his admission to the hospital; who visited and treated him during the hospital stay; and to whom he turned for follow-up care after discharge from the hospital. That doctor is usually the private patient's attending physician during his period of hospitalization.

The private patient has chosen and, in effect, contracted with his doctor, whereas the institutional patient—without a private doctor of his own—has an attending physician assigned to him by the hospital. The institutional patient, in effect, looks to the institution for his medical care rather than to a private physician.

The problem in making medicare payments does not arise with respect to the bona fide private patient of a physician in private practice who is cared for in the teaching hospital—that has been, and should continue to be, treated just as any other billable service relationship between doctor and patient. That type of doctor-patient relationship is 1-to-1 with each recognizing an obligation to the other.

Serious questions have arisen, however, with respect to payments to supervisory physicians designated as attending physicians for medicare beneficiaries who are institutional patients. These policy questions relate to payments made in some teaching hospitals for services which constitute, at the very least, abuse of medicare. (See, for example, the report submitted to the Committee on Finance by the Comptroller General of the United States with respect to payments to supervisory physicians in the Cook County Hospital.¹) In connection with this and similar situations, the staff suggests that the committee urge the Social Security Administration to undertake a careful audit of all payments made to date for the services of supervisory physicians in all teaching hospitals and that where payments were improperly made, every effort necessary be undertaken by the Government to recover such improper payments.

Related Social Security Administration Action

In recent months the Social Security Administration has taken steps to tighten up procedures and requirements for payment of teaching physicians. In a letter addressed to part B carriers on September 3, 1969, the Bureau of Health Insurance noted that: "Pursuant to our teletype of June 20, many carriers suspended payment for services of teaching physicians where it appeared that requirements for payment for services in a teaching setting were not being met * * *"

The same letter recited criteria for determining the validity of a supervisory physician's charge under Social Security regulations. One of those criteria recognizes the distinction between a service patient (institutional patient) and a private patient: "* * * (d) is the private physician of the patient *or* the patient is a service patient assigned to him as attending physician * * *."

In somewhat understated terms, the Bureau of Health Insurance advised part B carriers that:

"Questions as to fulfillment of the attending physician role are more likely to occur with reference to service patients than the private patients of a physician in a teaching setting utilizing the services of residents and interns in the care of his patients. Sometimes a physician assigned as 'attending' for a service patient in fact has little to do with the actual care and treatment of the patient. In contrast, the personal physician of a private patient in a teaching setting will ordinarily meet the above requirements.

"Carriers may find it possible to resume payments promptly for one category of billings for services in a given hospital with suspension of payment continuing longer for another category. For example, a carrier might resume payment for services provided private patients in a teaching setting while continuing to resolve problems connected with the identification of the attending physician and recordation of services rendered to service patients."

Little Health Insurance Precedent for Payments to Supervisory Physicians

Prior to medicare, few Blue Shield plans or commercial health insurers paid on a fee-for-service basis for supervisory services rendered

¹ Appendix A of hearings before the Committee on Finance entitled "Medicare and Medicaid," July 1 and 2, 1969.

by teaching physicians in teaching hospitals. Relatively few teaching institutions even attempted to bill for such services—it was not “customary” nor did it “prevail.”

In those cases where payment was made on a fee-for-service basis by a third-party insurer, it was made on a limited basis and usually only if: (a) other patients were similarly charged; (b) a charge was made and payment customarily expected from insured and non-insured patients alike; (c) the service billed for was clearly described and personally provided; and (d) there was a legal obligation on the part of the patient to pay such a charge. One of the Nation's largest insurance companies replied to staff questions concerning payments to supervisory physicians as follows:

“In our regular business, we are seeing billings of this nature with increasing frequency since the advent of medicare, although the practice is by no means uniform throughout the country and in institutions of different sizes and types of teaching programs. When such charges are received, we are recognizing them where all available information indicates they are valid and nonduplicatory. Prior to July 1, 1966, such charges were quite infrequent to the point of being almost nonexistent. Our practice at that time was generally not to recognize them although payment was made in occasional special circumstances.”

Another very large insurance company put it this way:

“In connection with our own policies, most exclude any charge which the employee would not be required to pay if there were no insurance. Many teaching hospitals bill for patients treated by staff physicians only if there is insurance available. When this practice is identified, we do not accept the bill.”

In a candid response to the staff questionnaire, another dominant company stated:

“The regulations issued by the Social Security Administration in connection with such services has, in all likelihood, resulted in our policyholders being charged for supervisory physician services in a teaching setting without our even being aware of it in many instances. In our regular business, we have always taken the position that we would only pay the physician for services actually performed by him. We have not paid physicians for services performed under his supervision. As indicated above, prior to July 1, 1966, supervisory physicians in a teaching setting did not normally render bills for their services, and if they had, we would not have paid for services not actually performed by the physician.”

And, with even greater candor, another major health insurer said:

“It is evident that the overall program expenditures for services rendered in a teaching setting are extremely large. We feel that this area might be removed from the scope of the program and, in turn, that subsidization of teaching institutions be done by the issuance of Federal grants.”

With respect to nonprofit carriers such as Blue Shield, responses included these:

(a) “Rarely are our contract holders charged for such services. We do not pay for such charges. We had occasional instances of such billing prior to July 1, 1966. We do not pay for them under our own contracts if we are aware of the circumstances.”

(b) "To the best of our knowledge our own subscribers are not charged for such supervisory services. We provide no benefits for such services, and we would not knowingly pay for such services. It has never been the custom in this area to charge for supervisory services."

(c) "Over the years, Blue Shield has accepted as participating physicians some physician-teachers employed by teaching hospitals * * * with the explicit understanding services reported to Blue Shield would involve patients from their private sector practice. In addition, it was understood that these physician-teachers would personally be present and directly involved in the patient's care * * *."

(d) "We are confident that our subscribers are charged in the same manner as medicare beneficiaries. This means that there are no such charges being made to our knowledge. In the case that we did know of such charges, we would not pay them under our Blue Shield contracts."

(e) "We have established individual code numbers for physicians to delineate between service patients and private practice patients. * * * arrangements were made prior to billing by any physician in a teaching relationship * * * to submit fees for only those who are private patients."

(f) "In New York State it had previously been determined that such patients are under no legal obligation to pay for such services."

(g) "If the patient is classified as a private patient the physician can charge Blue Shield for his services. A private patient is one with whom the physician has an express or implied contract to render services for a fee."

Medicare Payments Made Where There Was No Legal Obligation To Pay

The last sentence in (g) above is key to a great deal of the reservation about payment for supervisory services under part B of medicare. It is difficult to find a particular point in time or other definite event—or even sequence of events—at which the institutional or service patient expressly or impliedly contracts with a specific supervisory physician to pay him agreed-upon fees for agreed-upon services. In fact, it is doubtful if any of the supervisory physicians who billed medicare for institutional patients have identified themselves, as such, to the service patient in advance as "his" doctor and discussed the fees which the patient would be expected to pay for that physician's services.

It is not logical to assume that the medicare patient automatically obligates himself (and medicare) to pay that supervisory physician hundreds of dollars in the absence of an express recognition of obligation between that patient and that physician.

During the committee's hearing on medicare and medicaid (July 2, 1969) Social Security Administration witnesses were questioned extensively on the legal obligation to pay a supervisory physician. Their responses are not persuasive.

First, in response to a question by Senator Miller, Mr. Blumenthal, Assistant General Counsel for Health Insurance, stated:

"In most instances the courts which have ruled on this issue have found an implied obligation to pay *in situations where*

*emergency services have been furnished by physicians to emergency patients in hospitals * * **" (Emphasis supplied.)²

The staff do not quarrel with the courts or Social Security on that point. The *emergency patient* in most cases does not have an opportunity or time to expressly contract and agree with a given physician. It appears reasonable, therefore, to recognize an implied obligation in emergency situations—particularly where the patient would customarily have been charged if there had been time before the rendering of services to discuss such matters. However, one still cannot conclude from Mr. Blumenthal's response that the courts would necessarily recognize an implied obligation to pay—even in an emergency situation—for the services of a "supervisory physician," as those services are defined under medicare regulations. On the other hand, reference to court rulings with respect to emergency patients is not particularly responsive or relevant to the issue of billings by "supervisory physicians" for institutional patients who, in the main, are not emergency cases.

Second, a colloquy between Senator Bennett and Mr. Blumenthal on the question of legal obligation to pay for the services of "supervisory physicians" contains a contention by Social Security that the legislative history of medicare with respect to payment of hospital-based specialists "clearly parallels" the matter of payment to "supervisory physicians" and "** * * influenced us [Social Security] in large measure in reaching the conclusion we did on the issue * * **"

As Mr. Blumenthal noted, the hospital-based specialists who were the subject of extensive congressional debate relative to appropriate methods of reimbursement were specifically "** * * the physicians who practice pathology, radiology, anesthesiology, and include also the psychiatrist, physical medicine.*"³

A portion of the colloquy between Senator Bennett and Mr. Blumenthal went as follows:

MR. BLUMENTHAL. Now, in these instances, sir, the arrangement for services is not made by the patient with the physician. The parallel, I think, is quite clear, and I think also it influenced us in large measure in reaching the conclusion we did on the issue that we are discussing now.

SENATOR BENNETT. That history was on the typically hospital-based service doctor, the radiologist, the pathologist, the anesthesiologist. I am sure that neither committee ever expected that this would be spread out to apply to the surgeon and the internist, and all of the rest of these people who are now collecting these fees. Are you suggesting to us that we actually intended that surgeons and other practitioners, other specialists should be considered as hospital-based?

MR. BLUMENTHAL. I believe that the legislative history so reveals, sir, although the committees made reference to these specific specialties, the discussion centered on those physicians who are hospital-based because their remuneration was received by or through the hospital, not with regard particularly to the type of practice that they engaged in.⁴

The following observations bear out the correctness of Senator Bennett's understanding:

1. The hospital-based specialists—radiologists, pathologists, anesthesiologists and psychiatrists—had specifically been recognized as such

² "Medicare and Medicaid", hearings before the Committee on Finance, July 1 and 2, 1969, p. 226.

³ Ibid, p. 243.

⁴ Ibid, p. 243.

prior to medicare's enactment by most third-party payment organizations. Payment for their services—unlike the services of supervisory physicians—was routinely costed or charged and reimbursable prior to medicare as either a hospital or medical expense.

2. The issue debated by the Congress with respect to the four specialties was not whether those services should be compensated. There was general recognition by the Congress that a cost was incurred for the services of *those* specialists. The issue revolved around whether the services of those specialties should be reimbursable under part A as a hospital expense or under part B as a medical expense.

3. The question of whether the services of the radiologist, pathologist, and anesthesiologist should be billed for by the hospital or by the physician was a major issue in medical care antedating medicare's enactment by many years. No comparable history exists with respect to payment for the services of "supervisory physicians."

4. Patients customarily were expected to and did pay prior to medicare for the services of the four medical specialties—either as a hospital charge or as a medical charge.

5. Finally, there is an elementary and basic difference between billing for the services of the four specialists and those of "supervisory physicians." The anesthesiologist, radiologist, pathologist, and psychiatrist seldom are designated as a patient's "attending physician" theoretically responsible for the course of his total care while in the hospital. Those specialists are responsible for restricted elements of patient care—not its totality—and the service they provide is of a highly specialized and technical nature.

Supervisory Physician Payments as Back-Door Federal Support for Medical Schools; Advisory Group Planned It That Way

The dean of one of the Nation's finest medical schools familiar with the issue of payments for the services of "supervisory physicians" in teaching institutions addressed some candid remarks to the staff. Conceding problems and not arguing any historical basis for payment, the educator noted relative to the distinction between the private patient and the institutional patient:

"We are dealing here with two methods or systems of rendering patient care which I believe the authors of the medicare law did not fully appreciate. The law and SSA regulations are tending to make falsifiers out of many faculty members in teaching hospitals."

The latter observation presumably refers to the fact that under Social Security regulations a supervisory physician must, in effect, certify to the rendering of actual care and direct involvement with a patient in order to submit a charge.

The pressure and concern with respect to payment of supervisory physicians for institutional patients is essentially generated by the teaching hospitals and medical schools rather than by the physicians themselves. That concern is understandable; the substantial income developed by charging private patient fees for institutional patients flows, in the main, directly or indirectly to the hospital or medical school.

As the same medical school dean put it: "Medical schools incur an identifiable cost in rendering medical care in a teaching hospital. * * * Indeed, I believe that a "reasonable profit" from patient services

should be acceptable * * *. Many medical schools keep their doors open through the profits generated by their faculty from patient care fees * * *."

At a symposium on graduate medical education held in Atlantic City on October 14, 1968, Mr. Arthur E. Hess, Deputy Commissioner of Social Security (and Director of the Bureau of Health Insurance during medicare's initial days) discussed the question of compensation of the teaching physician under medicare. After pointing out that the consultant group appointed by Social Security to advise them on the matter was "composed of representatives of medical education and various physician organizations", Mr. Hess noted that the function of the group was "to consider the extent to which the services of the teaching physician could be viewed as a medical service to the patient personally and hence a service chargeable on a fee basis."⁵

As Mr. Hess pointed out, the advisory group did not fail to recognize the advantages of reimbursement under medicare. Commenting on the group's work he said:

"During the discussion they emphasized that payment of such charges would not only provide compensation for the valuable medical care furnished *but that it could provide needed financial support for medical education*, thus benefiting patients generally. They also recognized that the elderly could not attain the same status as other insured patients if they were not provided the means of paying their own way." (Emphasis supplied.)

Mr. Hess then noted that: "These considerations were persuasive and were taken into consideration in formulating the regulations."

That teaching hospitals and medical schools are chronically hard pressed for funds almost goes without saying. Congress has recognized the financial problems of those institutions and assisted with appropriations aggregating many hundreds of millions of dollars.

However, it is another question entirely, as to whether the Nation's aged should also be asked to subsidize medical education with many millions of dollars from their part B premium payments. This latter subsidization takes place without the benefit of the orderly procedures of justification and assignment of priorities which are part and parcel of the regular appropriation process.

Medicare Payments Differ Sharply From Usual Fee-For-Service Payments

With respect to the elderly attaining "the same status as other insured patients," it could almost be said that they have surpassed that. Fees charged medicare for services of teaching physicians to institutional patients have generally been comparable or identical to those charged or chargeable by the teaching physician for the more extensive time and services he renders in care of a private patient. Yet, the fees paid to the teaching physician by his private patients if he is also in the usual private practice—in contrast to those for the institutional patient—are not routinely routed back to the hospital or medical school—they are usually retained by the physician. The fee assessed against medicare with respect to the aged institutional patient on the other hand is afforded the singular privilege of being converted into a subsidy for the teaching hospital or medical school. If the

⁵In retrospect, the establishment of an advisory body, consisting solely of those who could benefit from their own recommendations, with a mandate to determine how the Government would pay them for services, which had previously not been paid for, was a decision somewhat lacking in judgment.

medicare institutional patient's care is identical with that of the private patient, as some advocates of these supervisory subsidies contend, why should one type of payment often go one way and the other in a different direction?

There are additional aspects to the hospital's concern with collection of fees for physicians' services. First, while part B requires the beneficiary to pay at least 20 percent of the charges for doctor care, there is little evidence that beneficiaries are being routinely billed or collection sought with respect to charges for the services of supervisory physicians. Obviously, therefore, such charges are not treated on the same basis as private physician billings.

Secondly, there arise questions of duplicate payment by medicare for physicians' services in connection with a given beneficiary who is an institutional patient in a teaching hospital. The costs of the interns and residents who may provide the bulk or all of his institutional care are reimbursed as a part A hospital expense. The teaching physician, assigned as attending physician, may then come along and bill his "customary and prevailing" fee under part B for that patient's care.

The Week for Hospitals, a publication of the American Hospital Association, in its issue for November 7, 1969 contained an item quite pertinent to the "double-payment" question:

DEAN OUTLINES TEACHING HOSPITAL PARADOX

The contradictions involved in using patient care funds for teaching purposes were outlined by Robert Ebert, M.D., dean of the Harvard Medical School, at the annual meeting of the Association of American Medical Colleges. Cautioning against the possibility of making double third-party payments to teaching hospitals, he said: "... some of the best teaching services advertise that substantial responsibility is delegated to interns and residents. Now the same teaching service must insist that it is really the visiting physician who has the responsibility. . . . It is difficult to make these two arguments sound convincing when they are made simultaneously by the same person."

Staff Recommendation

The staff is aware that the involvement of teaching physicians in direct patient care varies with respect to a given patient from none to

extensive. We also recognize that charges were normally not made nor payment anticipated, by teaching physicians for institutional patients prior to medicare.

The staff concludes that there is no justification under the present medicare statute for reimbursement of supervisory physician services to an institutional patient in a teaching setting and that there is no legal obligation on the part of the patient to pay him for those services.

For those reasons, we recommend that this type of reimbursement be terminated until such time as Congress clearly and specifically expresses an intention to reimburse for these services and specifies the criteria under which they will be reimbursed.⁶

⁶ In the event the committee desires to explore this possibility prospectively a reasonable structure for such payments might include the elements outlined below. Almost by definition, the supervisory physician, regardless of how much or how little direct patient care he renders, essentially functions in a teaching or instructional capacity with respect to institutional patients. Medicare now reimburses under part A for that portion of his salary or stipend attributable to administrative and teaching responsibilities. The portion of time presumably spent in functioning as a supervisory physician has been reimbursed under part B usually on a fee-for-service basis. It is the latter which has been the source of abuse and overpayment.

No matter how detailed or well-devised a reporting form might be constructed to provide, on paper at least, a minute breakdown of the specific professional components—intern, resident, supervisory physician—of the in-hospital medical care provided to an institutional patient, medicare has no effective mechanism for checking the validity of the answers.

Recognizing this problem, and recognizing, also, that any effective method of reimbursing for "supervisory" services should be self-contained and self-policing, we would suggest for consideration the following approach to payment for the services of supervisory or teaching physicians to institutional patients:

1. Such costs should be recognized and payable *only* under part A and only where the physician is compensated on the basis of a fixed reasonable salary or stipend payable at regular periodic intervals by the institution (or medical school) and only to the extent of such salary or stipend actually paid. No fees for service should be payable under medicare.

2. The costs should be payable 100 percent under part A.

3. Payment should be made by medicare *only* to the extent of its proportionate share of such costs and only where *all patients* are required to pay for such services in an institution and bona fide efforts are made by the institution to collect from all patients.

4. Subject to the above limitations, reimbursement should be authorized to a teaching institution only if and only in the same degree or proportion that such supervisory services are reimbursable under the most widely-held contracts or policies issued by the non-governmental third-party payer whose payments are the largest for that hospital's services, or by the part B carrier in the area concerned, and only if both organizations, if different, make such payments when such supervisory services are provided to their own policyholders or subscribers on the same basis and under the same conditions for which payment is requested for medicare beneficiaries.

5. Where the supervisory physician is a part-time teaching physician who is compensated for medicare institutional patients in accordance with the conditions of 1 through 4 above, he should not be precluded from billing on a "fee-for-service basis" under part B for other medicare beneficiaries who are bona fide "private patients." These would ordinarily consist of patients who were seen by him in his office prior to hospital admission; for whom he arranged admission to the hospital; who were visited and treated by him during their hospital stay; who would ordinarily turn to him for follow-up care after discharge from the hospital; and who are legally obligated to pay the charges billed, including deductibles and coinsurance, and from whom collection of such charges is routinely and regularly sought by the physician. Of course, appropriate safeguards should be established to preclude fee-for-service payment on the basis of pro forma or token compliance with these private patient criteria.

CHAPTER SEVEN

LARGE PAYMENTS TO HEALTH CARE PRACTITIONERS

Data on Practitioners Receiving More Than \$25,000 in 1968

The Appropriations Committee of the Senate annually secures and publishes a listing of those to whom payments aggregating \$5,000 or more, are made by the Department of Agriculture. Additionally, where crop support and other Agriculture Department payments aggregate \$600 or more, those amounts are routinely and regularly reported to the Internal Revenue Service.

Against that background, the staff requested the Department of Health, Education, and Welfare to prepare two listings: first, a list of all health care practitioners paid \$25,000 or more directly or indirectly under one or more of the welfare health care financing programs (principally medicaid); and second, a similar listing of all physicians paid \$25,000 or more by medicare in 1968. Each of these practitioners was to be identified by name and address; total payments; medical specialty; group or solo practice; and number of different medicare or medicaid patients treated. The amounts paid include payments made directly to the practitioner through assignment of benefits to him by patients, as well as payments made to medicare patients on the basis of that practitioner's bills to them.

It was believed that the medicare and medicaid lists would be helpful in evaluating and screening the range and types of payments to those receiving substantial sums of public money as well as the effectiveness of claims control procedures.

Physicians Listed

Prior to actual collection of the information, social security personnel estimated that the number of physicians paid \$25,000 or more by medicare would probably be 2,200 or 2,300. The list, still incomplete, consists of almost 4,300 physicians—almost double the estimate of the Bureau of Health Insurance. As tables 3 and 4 indicate, the staff was careful to request that individual practitioners be distinguished from group practitioners.

In the case of medicare, the data gathered by the Bureau of Health Insurance for the committee is incomplete. In all probability, at least 5,000 individual practitioners were paid \$25,000 or more in 1968. As the explanatory attachment to the tables notes, the numbers of different physicians receiving large payments is understated. A substantial number of medicare carriers and some States experienced difficulty in determining and providing the basic data requested. In the case of medicare, there were carriers who initially refused to identify even for the Department of Health, Education, and Welfare the names of those to whom these large payments had been made. Those carriers became more responsive to the request for information

following communication to them of some rather basic viewpoints and alternatives suggested by the chairman of the Finance Committee and the Social Security Administration.

Data were particularly inadequate with respect to medicaid payments in the two States—New York and California—which account for the lion's share of medicaid expenditures. New York City, for example, could not identify the number of different welfare recipients provided services by a given practitioner nor could they tell whether the practitioner was in solo or group practice.

Following receipt of the medicaid payments data, the staff submitted the information to the Bureau of Health Insurance with a request for the amounts, if any, paid under medicare to each physician who had received \$25,000 or more from medicaid. The combined payments tables—admittedly incomplete—appear as appendix B, p. 163. Physicians are identified solely by code number and State. As will be noted, a substantial number of physicians each received payments aggregating \$100,000 or more from the two programs.

Tables 3 and 4 which follow indicate the numbers of physicians in private practice who each received \$25,000 or more from medicare in 1968, as well as payments of \$25,000 or more to groups. *The tables are incomplete and partial—particularly inasmuch as the Bureau of Health Insurance and the carriers were unable to identify total medicare payments to thousands of hospital-based radiologists, pathologists, and anesthesiologists.* The data is provided by State and by range of payments. Additional tables in appendix A, p. 151, present further refinements of the data by medical specialty, number of beneficiaries treated, place of treatment, average payment, and so forth. The amounts paid are, in the main, after subtraction of deductible and coinsurance payments required to be paid by the beneficiary to the physician. For that reason, it is necessary to add at least 25 percent more to the medicare payments actually listed in order to determine the total payments to physicians by medicare and by the beneficiary patients.

More Detailed Profile Data Indicate Possible Abuse and Fraud

The staff requested additional payments data for 1,600 of the 4,300 individual physicians who were identified as having been paid \$25,000 or more under medicare. These were physicians who, based upon available data, appeared to have somewhat unusual patterns of practice, such as high proportions of care rendered in the form of nursing home or hospital visits or where unusually high amounts were paid for laboratory or X-ray services, and so forth. Those selected for further screening consisted primarily of physicians with particularly high payments totals such as \$75,000 or more. Unfortunately many carriers were unable to reply fully or respond in usable form with respect to the payments profile data request submitted to them. For the benefit of the committee, reproduced below is an actual completed payments profile for an individual doctor submitted in response to the staff's request.

TABLE 3.—Physicians reimbursed \$25,000 or more under medicare during calendar year 1968: Number of physicians, by State, and amount reimbursed (excludes physicians known to be in group practice)

State	All physi- cians	Number of physicians by amount reimbursed (in thousands)											
		25 to 29.9	30 to 34.9	35 to 39.9	40 to 44.9	45 to 49.9	50 to 74.9	75 to 99.9	100 to 124.9	125 to 149.9	150 and over		
All States.....	4, 284	1, 595	960	552	340	226	432	111	40	10	18		
Alabama.....	83	39	21	5	5	4	7	1	1	—	—		
Alaska.....	—	—	—	—	—	—	—	—	—	—	—		
Arizona.....	19	7	2	2	3	3	1	1	—	—	—		
Arkansas.....	37	14	11	3	3	—	5	1	—	—	—		
California.....	370	176	64	53	20	18	25	11	3	—	—		
Colorado.....	49	18	12	9	4	1	5	—	—	—	—		
Connecticut.....	65	37	9	11	5	2	1	—	—	—	—		
Delaware.....	5	3	2	—	—	—	—	—	—	—	—		
District of Columbia.....	21	9	5	1	—	—	6	—	—	—	—		
Florida.....	879	226	178	96	70	64	160	48	23	7	7		
Georgia.....	75	36	15	7	5	6	4	1	—	—	—		
Hawaii.....	4	3	—	1	—	—	—	—	—	—	—		
Idaho.....	6	1	3	—	1	—	—	—	—	—	—		
Illinois.....	247	95	51	39	18	14	22	5	3	—	—		
Indiana.....	23	11	6	4	1	—	1	—	—	—	—		
Iowa.....	62	25	14	9	3	3	6	2	—	—	—		
Kansas.....	16	10	3	2	1	—	—	—	—	—	—		
Kentucky.....	41	16	6	9	7	2	1	—	—	—	—		
Louisiana.....	14	8	5	—	1	—	—	—	—	—	—		
Maine.....	11	8	2	—	1	—	—	—	—	—	—		
Maryland.....	39	21	8	3	4	1	1	1	—	—	—		
Massachusetts.....	86	28	32	15	7	1	1	1	—	—	—		
Michigan.....	51	18	13	8	6	2	3	—	1	—	—		
Minnesota.....	81	30	20	14	5	4	5	2	—	—	—		
Mississippi.....	40	13	11	6	3	1	6	—	—	—	—		

See footnote at end of table.

TABLE 3.—Physicians reimbursed \$25,000 or more under medicare during calendar year 1968: Number of physicians, by State, and amount reimbursed (excludes physicians known to be in group practice)—Continued

State	All physi- cians	Number of physicians by amount reimbursed (in thousands)													150 and over
		25 to 29.9	30 to 34.9	35 to 39.9	40 to 44.9	45 to 49.9	50 to 74.9	75 to 99.9	100 to 124.9	125 to 149.9					
Missouri	166	66	42	18	13	11	14	1							
Montana	4	1	2	1											
Nebraska	44	13	10	7	2	4	4	2	1	1					
Nevada	7	2	1		3	1									
New Hampshire	6	2	2	1	1										
New Jersey	345	111	88	56	38	20	25	5	1						
New Mexico	2	1		1											
New York	392	152	94	48	24	15	43	10	3						
North Carolina	45	15	12	9	5	1	2	1							
North Dakota	12	3	3	4	1	1									
Ohio	90	40	25	8	7	6	3	1							
Oklahoma	36	18	9	6	1		2								
Oregon	17	6	5	3	2	1									
Pennsylvania	118	45	29	13	13	4	9	3	1	1					
Rhode Island	26	12	6	4	2		2								
South Carolina	17	8	3	2	2		2								
South Dakota	8	2	3	1	1	1									
Tennessee	81	39	17	8	4	3	7	3							
Texas	370	135	72	37	39	25	47	9	2	1					
Utah	10	6	1	3											
Vermont ¹															
Virginia	33	12	9	5	1		3	2	1						
Washington	21	7	7	3	1	1	2								
West Virginia	19	8	3	3	2	1	2								
Wisconsin	77	31	22	10	5	4	5								
Wyoming	1	1													
Puerto Rico	5	2	1	1		1									
Travelers-Railroad	8	5	1	2											

¹ Totals for Vermont included in totals shown for New Hampshire.

TABLE 4.—*Number of group practices reimbursed \$25,000 or more under medicare during calendar year 1968 by State and amount reimbursed*¹

State	Number of physicians by amount reimbursed (in thousands)													
	All physicians	25 to 29.9	30 to 34.9	35 to 39.9	40 to 44.9	45 to 49.9	50 to 74.9	75 to 99.9	100 to 124.9	125 to 149.9	150 to 199.9	200 and over		
All States	905	203	145	91	56	58	152	69	27	23	25	56		
Alabama	10	1	1	2	1	—	—	1	—	3	—	1		
Alaska	—	—	—	—	—	1	—	—	—	—	—	—		
Arizona	11	5	5	—	—	—	—	—	—	—	—	—		
Arkansas	29	5	5	2	3	3	5	3	2	—	—	1		
California	156	30	27	14	10	6	25	17	3	3	9	12		
Colorado	3	1	—	—	—	—	1	—	1	—	—	—		
Connecticut	7	2	2	—	—	—	1	—	—	2	—	—		
Delaware	1	—	—	—	—	—	1	—	—	—	—	—		
District of Columbia	17	4	3	2	1	2	2	1	—	—	—	2		
Florida	—	—	—	—	—	—	—	—	—	—	—	—		
Georgia	—	—	—	—	—	—	—	—	—	—	—	—		
Hawaii	2	1	1	—	—	—	—	—	—	—	—	—		
Idaho	8	3	—	2	—	—	2	1	—	—	—	—		
Illinois	17	1	1	—	—	—	5	4	—	2	—	4		
Indiana	43	16	6	6	2	3	5	1	1	—	2	1		
Iowa	15	3	1	2	—	—	6	—	1	—	—	2		
Kansas	34	4	6	3	3	—	7	1	3	—	1	3		
Kentucky	3	1	1	—	—	1	—	—	—	—	—	—		
Louisiana	12	4	3	—	—	1	1	—	1	—	—	2		
Maine	1	—	—	1	—	—	—	—	—	—	—	—		
Maryland	4	2	1	1	—	—	—	—	—	—	—	—		
Massachusetts	37	8	9	4	1	4	6	1	—	2	—	2		
Michigan	6	1	1	1	—	2	—	—	—	1	—	—		
Minnesota	68	19	11	4	4	5	9	5	3	1	2	5		
Mississippi	6	1	1	1	—	—	2	—	1	—	—	—		

TABLE 4.—*Number of group practices reimbursed \$25,000 or more under medicare during calendar year 1968 by State and amount reimbursed*¹—Continued

State	All physi- cians	Number of physicians by amount reimbursed (in thousands)													150 to 199.9	200 and over
		25 to 29.9	30 to 34.9	35 to 39.9	40 to 44.9	45 to 49.9	50 to 74.9	75 to 99.9	100 to 124.9	125 to 149.9						
Missouri-----	18	1	4	6	1	1	4	1								
Montana-----																
Nebraska-----	14	2	1		1	1	3	2	3				1			
Nevada-----	2	2														
New Hampshire-----	9	2	1	3	1					1				1		
New Jersey-----	3	2			1	1	2					2				
New Mexico-----	3			1			1							1		
New York-----	18	4	6	2	2		3	1								
North Carolina-----																
North Dakota-----																
Ohio-----	46	16	5	4	5	3	6	5	1	1						
Oklahoma-----	9	3	1	1		2		1			1					
Oregon-----	23	8	5	3	1	2	1	3								
Pennsylvania-----	35	7	6	7	4	3	5		1		1		1	1		
Rhode Island-----	6	4					1	1								
South Carolina-----	1						1									
South Dakota-----																
Tennessee-----	22	4	2	3	2	2	5	2			1		1			
Texas-----	88	9	9	6	8	5	22	9	5	2	3		10			
Utah-----	9	1	1		2	1	3			1						
Vermont ² -----																
Virginia-----	17	4	3	1	1	1	2	2		2	1					
Washington-----	35	11	6	2	1	2	9	1	1					2		
West Virginia-----	5	1					2	1		1						
Wisconsin-----	25	4	6	5	1	1	2	3			1		2			
Wyoming-----	1		1													
Puerto Rico-----																
Miscellaneous-----	21	6	2	3		2	2	2		1				3		

¹ Represents number of clinics and group practices so identified in Social Security records. Number of individual physicians represented is not known. ² Included in New Hampshire.

The services provided, their frequency, and the amounts billed yielded this physician—a general practitioner—almost \$118,000 in 1968 for taking care of 300 medicare patients.

Based upon partial analysis of the total data returned, the staff believes that the majority of physicians for whom information was requested with respect to medicare or medicaid as presently structured, have dealt fairly with these Federal programs and with the Federal Government. However, hundreds of the payments profiles indicate that the physicians involved may be abusing the programs. For example, we found many general practitioners each paid \$15,000, \$20,000 or more for laboratory services. We found payments being made for inordinate numbers of injections. In many cases we found what appears to be over-visiting and gang-visiting of hospital and nursing home patients.

SECTION B.—MEDICARE REIMBURSEMENT AND PATIENT PROFILE

Type of service	Allowed charges	Number of patients	Number of services
PHYSICIAN IDENTIFICATION:			
NO. 002504			
1. Total.....	117,824.50	300	14,338
Less deductible and coinsurance.....	33,978.14		
Amount reimbursed.....	83,846.36		
2. Visits:			
A. Office visits.....	8,167.00	208	1,355
B. Home visits.....	1,620.00	29	154
Nursing home visits.....	83,020.00	104	8,332
C. Hospital visits.....	8,509.00	69	1,378
D. ECF visits.....	.00		
E. Outpatient clinic visits.....	.00		
3. Surgery:			
A. Surgical.....	679.00	19	21
B. Assistant surgery.....	505.00	9	9
4. Laboratory tests.....	10,461.00	208	2,136
5. Diagnostic X-ray.....	714.50	69	76
6. Therapeutic X-ray.....	.00		
7. Physiotherapy.....	.00		
8. Injectable drugs:			
A. Injection only.....	3,731.00	158	840
B. Office visit with injection.....	188.00	7	19
C. Home visit with injection.....	10.00	1	1
9. Psychiatric counselling.....	.00		
10. All other:			
A. Consultations.....	15.00	1	1
B. All other.....	205.00	12	16

Regular Reporting of Profile Information Basic to Proper Administration

In sum, it appears absolutely necessary that each carrier under medicare and each State's medicaid administrator be required to regularly compile and evaluate basic payments profile information with respect to each health care practitioner. The questionnaire developed by the staff undoubtedly can be modified and improved into a more effective screening device. Nonetheless, the kinds of data requested in the staff's rather elementary questionnaire are those which tend to indicate patterns of overutilization and overcharging.

Shortcomings exist with respect to the present capacity of the Government and its agent-carriers to undertake complete and professional evaluation and followup on their own of the specific data gathered on thousands of health care practitioners who were paid large sums under medicare and medicaid. It might be appropriate, therefore, to consult with and enlist the support of all professional organizations concerned which might be helpful in evaluation and follow-up programs. However, procedures which involve peer review by professional associations should not be undertaken without precise spelling out and assurances that such review will be comprehensive and effective—not paper and token. In this connection, John Veneman, Under Secretary of HEW, indicated to the committee in his testimony, the type of pitfall to be avoided when he noted that: “. . . too often peer review becomes peer justification.”

The staff would also suggest that each State be routinely and regularly provided medicare payments profile data with respect to physicians practicing in that State. Such information would enhance the State's utilization and cost control capacity in its medicaid program inasmuch as many physicians serving medicare beneficiaries also care for medicaid recipients.

CHAPTER EIGHT

INCENTIVE REIMBURSEMENT METHODS FOR HOSPITALS, EXTENDED CARE FACILITIES AND PHYSICIANS UNDER MEDICARE

With a view toward spurring increased efficiency and economy in the medicare and medicaid programs, the staff is working to perfect an incentive reimbursement system. We believe that effective incentives to improved performance will result if better-than-average performance is rewarded with a money payment—the better the cost control the larger the payment. This premise parallels (if it is not the same as) that underlying the competitive enterprise system—better performance and efficiency of operation yield higher returns.

We believe also that to be workable an incentive reimbursement system must recognize the role of the physician as the key to controlling major portions of health care costs. It is the physician who determines whether a patient is to be hospitalized or placed in an extended care facility. It is the physician who determines the patient's length of stay in a health care institution or a hospital. It is the physician who orders the endless variety of costly services—such as X-rays, laboratory services, and drugs—which are provided to the hospitalized patient.

The theory on which our work is progressing involves a sharing with the providers of health care of a portion of the savings to the medicare program growing out of their increased efficiency and greater control over utilization in the future as compared to the first 3 years of operation of medicare.

We also believe that to be effective, an incentive plan must include a disincentive to continued poor performance.

It is our hope that our recommendation for an incentive reimbursement system can be submitted to the committee at an early date and that it will stimulate the public discussion and consideration which must precede serious legislative action on so important and sensitive a matter.

CHAPTER NINE

CERTIFICATION OF EXTENDED CARE FACILITIES

The Original Congressional Concept

With the inclusion of posthospital extended care benefits under medicare, the Congress introduced a new concept into the hospital insurance program; an alternative, less costly institutional setting for the provision of medical care. The Finance Committee report in 1965 stated (pp. 30-32):

"Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients.

"* * * The hospital-transfer requirement is intended to help limit the payment of the extended-care benefits to persons for whom such care may reasonably be presumed to be required in connection with continued treatment following inpatient hospital care and makes less likely unduly long hospital stays. * * *

"Extended care facilities would also be required to satisfy a number of conditions necessary for an institutional setting in which high quality convalescent and rehabilitation care can be furnished. These include conditions relating to the provision of around-the-clock nursing services with at least one registered nurse employed full time, the availability of a physician to handle emergencies, the maintenance of appropriate medical policies governing the facility's skilled nursing care and related services, methods and procedures for handling drugs, and utilization review. In addition to the conditions specified in the bill, the Secretary would be authorized to prescribe such further requirements to safeguard the health and safety of beneficiaries as he may find necessary."

The concept is succinctly restated in a recent Social Security Administration directive to intermediaries (Bureau of Health Insurance Intermediary letter No. 370, April 1969, p. 2):

"*Concept of Extended Care.*—The term 'extended' refers not to provision of care over an extended period, but to provision of active treatment as an extension of inpatient hospital care. The overall guide is to provide an alternative to hospital care for patients who still require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting."

Initial Estimates of Number of Qualified Facilities

While no precise figure was calculated, it was assumed by the Social Security Administration that about 2,000 institutions would be able to

qualify as extended care facilities during the first year of the medicare program. The original actuarial estimate of the cost of posthospital extended care benefits included in the 1965 administration bill assumed that hospital insurance enrollees would spend 0.16 days per beneficiary in extended care facilities in 1967; that "benefits will be provided in accordance with a strict interpretation of the language in the bill"; that the utilization rate would increase as additional facilities qualified as ECF's until an ultimate rate of 0.31 days per year per beneficiary was reached.

The insurance industry projected a utilization rate more than six times as great in 1967—1.01 days per year per beneficiary. The industry based this on a concept of posthospital extended care benefits more closely related to the kind of skilled nursing home care benefit that had been provided under the Kerr-Mills program than to the type of benefits actually enacted. The legislative history makes clear that the Congress adopted a strict definition of post-hospital extended care benefits—as reflected both in the language of the committee reports and also in the financing of the hospital insurance program, for which cost estimates initially included only \$25 million to \$50 million for extended care benefits.

Extended Care Facility Standards High—On Paper

The "conditions of participation" (qualifications needed by an institution to be certified for medicare) for extended care facilities were tightly drafted with reasonably high quality standards, in conformity with the law and congressional intent. In the Social Security Administration's regulations, each "condition of participation" had included standards, and explanatory factors to be used in evaluating whether the standards had been met. For example, the condition of participation for nursing services requires a number of standards, three of which are quoted below (60 CFR 405.1124):

"(e) Standard; 24-Hour Nursing Service—There is 24-hour nursing service with a sufficient number of nursing personnel on duty at all times to meet the total needs of patients. The factors explaining the standard are as follows:

"(1) Nursing personnel include registered professional nurses, licensed practical nurses, aides, and orderlies.

"(2) The amount of nursing time available for patient care is exclusive of nonnursing duties.

"(3) Sufficient nursing time is available to assure that each patient—

"(i) Receives treatments, medications, and diet as prescribed;

"(ii) Receives proper care to prevent decubiti and is kept comfortable, clean, and well groomed;

"(iii) Is protected from accident and injury by the adoption of indicated safety measures;

"(iv) Is treated with kindness and respect.

"(4) Licensed practical nurses, nurses' aides, and orderlies are assigned duties consistent with their training and experience.

* * * * *

“(g) Standard; Dietary Supervision—Nursing personnel are aware of the dietary needs and food and fluid intake of patients. The factors explaining the standard are as follows:

“(1) Nursing personnel observe that patients are served diets as prescribed.

“(2) Patients needing help in eating are assisted promptly upon receipt of meals.

“(3) Adaptive self-help devices are provided to contribute to the patient's independence in eating.

“(4) Food and fluid intake of patients is observed and deviations from normal are reported to the charge nurse. Persistent unresolved problems are reported to the physician.

“(h) Standard; Nursing Care Plan—There is a written nursing care plan for each patient based on the nature of illness, treatment prescribed, long and short-term goals and other pertinent information. The factors explaining the standard are as follows:

“(1) The nursing care plan is a personalized, daily plan for individual patients. It indicates what nursing care is needed, how it can best be accomplished for each patient, how the patient likes things done, what methods and approaches are most successful, and what modifications are necessary to insure best results.

“(2) Nursing care plans are available for use by all nursing personnel.

“(3) Nursing care plans are reviewed and revised as needed.

“(4) Relevant nursing information from the nursing care plan is included with other medical information when patients are transferred.”

Wholesale Certification of Facilities

Despite the high standards for extended care facilities, in the actual process of certifying facilities, nursing homes were not required to fully meet the conditions of participation. Rather, in applying these standards, all that has been required is *substantial compliance* and progress toward full compliance. The basic approach of the Social Security Administration was to attempt to certify as many nursing homes as possible as extended care facilities. In his First Annual Report on Medicare, the Secretary of Health, Education, and Welfare stated (pp. 34-35):

“State agencies mailed applications to over 13,000 nursing homes in mid-1966. They began immediately to make followup contact to provide advice and assistance to facilities which needed help in meeting the conditions of participation. By December 1966, nearly 6,000 facilities had filed applications, onsite surveys were being completed, and the other steps in the certification process were well underway.

* * * By January 1, 1967, when the extended care benefit provisions went into effect, approximately 2,800 facilities were in substantial compliance with the conditions of participation.

* * * By July 31, 1967, as a result of the assistance provided by the State agencies, an additional 1,400 facilities had been approved for participation. This brought the total number of participating extended care facilities to 4,160.”

The key phrase in the Secretary's report is “substantial compliance,” and this phrase permitted many of the high standards to be disre-

garded more often than they were applied in the certification process. Some facilities were certified as in "substantial compliance" which could not, by any reasonable criteria, be considered to be without significant deficiencies. By July 1967, only 740 of the extended care facilities which had been certified fully met the conditions of participation while 3,210 were considered to be in "substantial compliance" with the regulations—that is, they fell short of meeting the standards—many falling very far short. Another 210 facilities as of that date were unable to even meet the requirement of having a qualified charge-nurse for each tour of duty.

Few Facilities Have Moved From "Substantial" to Full Compliance

Although the goal of the Social Security Administration in 1966 had been that institutions in "substantial compliance" with the standards would be expected to progress to full compliance, the experience to date demonstrates that this expectation has not been fulfilled, and that most ECFs continue to fall short of meeting the standards of care Congress intended when it enacted the medicare program. Between July 1967 and July 1968, the number of extended care facilities in full compliance increased from 740 to 1,350. About two-thirds of the increase represented facilities moving from "substantial" to full compliance; the remaining 200 were facilities certified for the first time. Between July 1968 and July 1969, the number of facilities in full compliance grew only slightly, from 1,350 to 1,374.

Thus only about one-eighth of the 3,210 facilities not in full compliance in July 1967 were able to achieve full compliance within the next 2 years. The vast majority remain in the "substantial compliance" category.

Benefit Costs Soar

The 1967 cost of extended care benefits in facilities fully meeting the standards was about \$50 million, the upper figure in the actuary's initial estimate made in 1965 (he estimated a first-year cost of \$25 million to \$50 million, assuming a tight definition of "extended care facility" as in the law). But about four times that amount was also spent in 1967 for benefits in facilities not in full compliance with the standards.

Certification Granted Facilities Failing To Meet Even Minimum Nursing Care Standard

Apart from the facilities in full compliance and those in substantial compliance a third category of certified extended care facilities deserves special mention. The Social Security Act (sec. 1861(j)) defines an "extended care facility" as an institution (or a distinct part of an institution) which—

"(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

* * * * *

"(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;"

The conditions of participation require that there be "at least one registered professional nurse or qualified licensed practical nurse who is a graduate of a State-approved school of practical nursing on duty at all times and in charge of the nursing activities during each tour of duty." (20 CFR 405.1124(d)). It is difficult to understand how any facility not meeting this minimum nursing care standard could provide extended care benefits, defined in the regulations as intended "for those persons who, though they no longer require the level of intensive care ordinarily furnished in a general hospital, continue to need for medical reasons a level of care entailing medically supervised skilled nursing and related services on a continuing basis in an institutional setting." (20 CFR 405.1101(d)(1)).

Despite the law and the standards, the Secretary of Health, Education, and Welfare explained in his First Annual Report on Medicare, published in 1968 (pp. 34-35) that:

"The shortage of nursing personnel posed problems for many institutions. For that reason, the guidelines for certification permitted, in some instances, temporary conditional certification of facilities which were found to be deficient in meeting the requirement that they have at least one registered professional nurse or qualified licensed practical nurse (a graduate of a State-approved school of practical nursing) on duty at all times and in charge of nursing activities during each tour of duty. Such conditional certification of extended care facilities expired on April 1, 1968. Of the 250 facilities granted such conditional certification, over 200 now meet the requirements for regular certification; others have withdrawn as providers or have had their participation terminated."

During this conditional period, some \$10 to \$20 million was spent on payments to extended care facilities not meeting the minimum nursing care standards. It should be noted that despite the Secretary's statement quoted above, 10 facilities still were conditionally certified in July 1968.

The numbers of facilities in each category are shown in the table below:

	July 1967	July 1968	July 1969
In full compliance with the standards . .	740	1, 350	1, 374
In "substantial compliance" with the standards	3, 210	3, 340	3, 402
Certified despite failure to obtain qualified charge-nurses for each tour of duty	210	10	-----
Total certified	4, 160	4, 700	4, 776

The staff recommends that certification of facilities with deficiencies—other than those of an insignificant and minor nature—be prohibited.

Certification Loophole Permits Maximum Medicare Reimbursement

The Social Security Act permits an extended care facility to be either an institution or a "distinct part" of an institution. This was intended to permit designation of a wing or other portion of a facility as an extended care facility, where either a hospital could provide less intensive (and therefore less expensive) medical care or a nursing home had a distinct infirmary section with a high level of care. The most recent figures show 660 such "distinct parts" of hospitals certified as extended care facilities.

But this provision of law has been used in another way. About 800 nursing homes have had a portion of their institution certified as an "extended care facility." The vast majority of these "distinct part" ECF's are not in full compliance with the standards. In his Second Annual Report on Medicare, published in 1969, the Secretary states (p. 64):

"The proliferation of 'distinct part' extended care facilities is a matter which has caused some concern. Complex reimbursement and other administrative problems are sometimes involved where part of an institution is certified as an extended care facility while the remainder is left outside the medicare program. To remedy this, new rules on establishment of 'distinct parts' are being considered to allow for partial certification of an institution only where there is a genuine difference in levels of care based on medical needs of the patients, and not artificial breakdowns established principally to secure reimbursement advantages."

To our knowledge no action has been taken to date on the remedy recommended by the Secretary, and nursing homes continue to increase or decrease the number of "extended care" beds so as to maximize medicare reimbursement. At present, there need be no physical separation of beds or appropriate accounting separation of costs and it is difficult to determine which personnel work where. Surplus or unoccupied beds tend to be arbitrarily designated as "extended care" beds with resultant excess apportionment of costs to medicare.

The staff suggests that administration of the "distinct part" provision be modified to encompass only a physically and clearly distinct section of a practical size operated as a department with a separate nursing station. Further, clear accounting distinctions should be made for the "distinct part," and a reasonable vacant bed rate limitation applied to whichever is less, the actual unoccupied bed rate in the distinct part or the unoccupied bed ratio in the non-medicare portion of the facility.

CHAPTER TEN

MEDICAID SKILLED NURSING HOME—INTERMEDIATE CARE FACILITY RELATIONSHIP

1957 Legislation Establishing Concept of "Intermediate Care Facility"

In a major effort to control the rapidly-rising nursing home segment of Medicaid costs, the Committee on Finance approved in 1967 an amendment to Title XI of the Social Security Act which authorized Federal matching for a new classification of institutional care provided in "intermediate care facilities." The amendment, enacted as a provision of P.L. 90-248, was intended to provide lower-cost alternatives to skilled nursing home care where "intermediate care" was determined to be more appropriate to the needs of the assistance recipient.

Federal matching payments are available for vendor payments to intermediate care facilities under the same formula as is applicable to Medicaid payments. (Such payments for intermediate care may total as much as \$400 million in fiscal year 1971.) The intent of this liberal reimbursement procedure was to remove the financial incentive to States, which led them to classify recipients as in need of skilled nursing home care when in fact many recipients did not need that level of care. As the Committee Report on the 1967 Amendments described the situation :

At the present time old-age assistance recipients whose primary need is for care in an institution other than a skilled nursing home are frequently classified as in need of "skilled nursing home care" and placed in such institutions because of a decided financial advantage to a State under present matching formulas.

Title XIX does not provide Federal matching funds for institutional care which provides more than room and board, but less than skilled nursing home care—only for "skilled nursing home care." But, if a State classifies a needy individual as in need of "skilled nursing home care" it can receive unlimited Federal matching funds. If it classifies him as in need of other institutional care, the State receives the standard old-age assistance cash matching, which is available only up to \$75 a month on the average.

Thus, the Federal and State governments often may pay upwards of \$300 a month for skilled nursing home care for a patient who could be adequately taken care of in another type of institution for \$150 or \$200 a month. The American Nursing Home Association and the Department of Health, Education, and Welfare both advised the committee that as many as 50 percent of the assistance recipients in skilled nursing

homes are not, in fact, in need of skilled nursing home care. Thus, the committee has adopted an amendment to provide for vendor payments for needy people qualifying for OAA, AB, APTD who are or who should be in intermediate care homes * * * Intermediate care homes would be defined and licensed by the States and would be those institutions which provide *services beyond ordinary room and board but below the level of skilled nursing homes.*

This amendment could result in a reduction in the costs of Title XIX, by enabling States to *use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind is not needed.*

The committee expects that the institutions covered by this provision will be subject to *periodic professional review and audit as to the care provided and its appropriateness for individuals in such institutions.* The Secretary of Health, Education, and Welfare is expected to assist States in developing suitable review procedures to meet these objectives. (Emphasis supplied.)

Clearly, based upon the above statements, which form the essential legislative history, Congressional intent was that:

1. Intermediate care facilities be institutions providing lower levels of care than skilled nursing homes.

2. Recipients in intermediate care facilities would be those whose lesser needs for care were such as not to require skilled nursing home or hospital care.

3. By definition, intermediate care would cost substantially less than skilled nursing home care.

4. There be two basic interdependent classifications:

- (a) A general determination that an institution is an intermediate care facility, and,

- (b) A specific determination that the individual recipients' needs are such as to warrant and permit placement in a facility providing less care than that available in a skilled nursing home.

5. There be periodic professional evaluation and audit of the care in the facility in terms of its "appropriateness" to the needs of the individual assistance recipient for whom payment is being made.

The references to "appropriateness" and "periodic professional review and audit" indicate Congressional expectation that while overall reductions in institutional costs were anticipated, a lower cost facility was not to be used where the level of care was below that required by the individual recipient. The reverse is also true, namely, that a higher cost facility providing a level of care above that required by the individual recipient was also inappropriate.

Intermediate care was not intended as a mechanism for financing residential or boarding home care. It was, according to the statute, intended for those who:

"... because of their physical or mental condition (or both) require living accommodations and care which, as a practical

matter, can be made available to them *only* through institutional facilities; and *do not* have such an illness, disease, injury, or other condition as to *require the degree of care and treatment* which a hospital or skilled nursing home (as that term is employed in title XIX) is designed to provide." (Emphasis supplied.)¹

Intermediate care was to be utilized only where no alternative type and site of care was available which was more suitable to the needs of the individual recipient. Intermediate care is capable of being provided in a variety of types of facilities providing different levels of care ranging from more than boarding home to less than skilled nursing home care. However, while a scale of different levels of care could be employed, the individual recipient's needs were to govern in determining at which point on that scale he would be placed.

The assistance recipient for whom intermediate care was intended, again in the context of the legislative history, is an individual whose physical or mental limitations are such as to preclude the capacity to live independently even with the support of available out-of-institution services, such as home health care. The intermediate care recipient is in contrast to the skilled nursing home or hospital patient whose primary need is for regular medical and nursing care.

Why the Congressional Aim Was Not Achieved

Several major difficulties have emerged and are emerging in the actual implementation of the intermediate care provision which are costly and inconsistent with Congressional intent.

Wholesale Reclassification of Facilities

First, is the fact that, in general, States seeking Federal matching funds for intermediate care appear to have made no substantial effort to effectively define and classify ICFs. For example, two States, Ohio and Oregon, sought to define an ICF simply as any licensed nursing home which could not or would not qualify as a skilled nursing home under medicaid. This approach appears more to accommodate substandard nursing homes than to encourage development of reduced levels of care appropriate to the needs of persons capable of being transferred from skilled nursing homes. An outgrowth of this approach is the wholesale reclassification by States of facilities which on one day were approved as skilled nursing homes under medicaid and the next day miraculously transformed into intermediate care facilities.

Wholesale Change in Status of Patients

Second, the wholesale transfer in status of facilities from medicaid skilled nursing homes to intermediate care facilities was accompanied by wholesale and indiscriminate transfer of patients from one program to the other. This appears completely inconsistent with the Congressional intent that each skilled nursing home patient's needs be individually and professionally evaluated to determine whether his needs can be satisfactorily met in an intermediate care facility. Of necessity, professional appraisal of the individual patient must be undertaken *before* transfer to an intermediate care status. Blanket reclassification

¹ Sec. 1121(b) of the Social Security Act, as amended.

tion of patients to accomodate substandard nursing homes is not authorized under either the statute or legislative history. It is a subterfuge which distorts what was intended to encourage proper placement of the *individual* in a proper institutional setting.

Some States Attempt to Outflank Legal Prohibition to Gain Federal Funds

Third, in an effort to substitute Federal dollars for State dollars, several States are seeking to classify as intermediate care facilities, publicly-owned institutions for the mentally-retarded. Payments for care of the mentally-retarded in such public institutions is not, at present, eligible for Federal matching under medicaid.

While the Congress may desire at some future date to afford Federal matching funds for care of mentally-retarded persons in public institutions, Sections 6(a) of Title I, 1006 of Title X, 1405 of Title XIV, and 1605 of Title XVI, of the Social Security Act coupled with Section 121(b) of the Social Security Act Amendments of 1965, clearly appear to preclude Federal matching under existing law. Titles I, X, XIV, and XVI prohibit payment for care in a public institution, other than a medical facility. Thus a State would have to classify an institution for the mentally-retarded as a medical facility in order to except it from the statutory prohibition. However, Section 121(b) states:

“No payment may be made to any State under Title I, IV, X, XIV, or XVI of the Social Security Act with respect to aid or assistance in the form of medical or any other type of remedial care for any period for which such State receives payments under Title XIX of such Act, or for any period after December 31, 1969.”

Therefore if the institution for the mentally retarded were called a medical facility, no payments could be made except to the extent they were qualified and made through Title XIX. The Department of Health, Education, and Welfare does not classify mental retardation as a “mental disease” and the latter is the only form of mental condition coverable under the provisions of Title XIX.

Lower Level of Care Sometimes Costs More

Fourth, as has been noted, the statute and the legislative history leave no room for question as to intermediate care comprising lower levels of service than skilled nursing home care. Given those premises, no logical basis exists for paying an intermediate care facility as much or more than a skilled nursing home in the same geographic area.

As will be noted on the tables which follow, showing relative rates of payments to skilled nursing homes and intermediate care facilities, at least three States of the few for which data were available, Massachusetts, Ohio, and Rhode Island, each pay substantial numbers of intermediate care facilities at rates as great or greater than that allowed many skilled nursing homes under the medicaid programs in those States.

The staff recommends that appropriate legislative, or administrative action by the Department of Health, Education, and Welfare, be taken to prevent payments to intermediate care facilities at the same or higher rates than those made to skilled nursing homes in the same area.

REPORT ON RATES PAID FOR SKILLED NURSING HOME CARE AND
FOR INTERMEDIATE FACILITY CARE IN THE SIX STATES HAVING
APPROVED PLANS FOR INTERMEDIATE CARE FACILITIES AS OF
SEPTEMBER 1969²

1. District of Columbia: The District of Columbia has an approved plan for Intermediate Care Facilities but as of May 1969 no homes had been licensed in that category.

2. Georgia:

Skilled Nursing Homes:	<i>Number of Homes</i>
\$190 monthly rate-----	1
\$215 monthly rate-----	32
\$240 monthly rate-----	145
Total-----	178
Intermediate Care Facilities: \$190 flat monthly rate-	21

3. Maine:

Skilled Nursing Homes: \$300 flat monthly rate----	111
Intermediate Care Facilities: \$260 flat monthly rate.	35

4. Massachusetts. (*See attached tables*).

5. Ohio. (*See attached tables*).

6. Rhode Island. (*See attached tables*).

²Information supplied by Medical Services Administration, Department of Health, Education, and Welfare.

*Monthly rates paid to skilled nursing homes for care of title XIX patients,
by size of home—Massachusetts*

Monthly rate	Total	Number of beds					Unknown
		Under 30	30 to 59	60 to 89	90 to 119	120 or more	
Total	254	37	86	56	21	54
Under \$200.....							
\$200 to \$209.....	1					1	
\$210 to \$219.....	2	2					
\$220 to \$229.....							
\$230 to \$239.....	2		2				
\$240 to \$249.....	3	2	1				
\$250 to \$259.....	1	1					
\$260 to \$269.....	5	1		2	1	1	
\$270 to \$279.....	13	4	5	3		1	
\$280 to \$289.....	12	2	6	2		2	
\$290 to \$299.....	18	4	5	2		7	
\$300 to \$309.....	20		7	2	3	8	
\$310 to \$319.....	17		6	5	1	5	
\$320 to \$329.....	11	1	2	3	3	2	
\$330 to \$339.....	11		4	4	1	2	
\$340 to \$349.....	10	1	4	4		1	
\$350 to \$359.....	13	3	2	3	3	2	
\$360 to \$369.....	31	1	10	7	2	11	
\$370 to \$379.....	3		1	1		1	
\$380 to \$389.....	5	1	2	1	1		
\$390 to \$399.....	4		1			3	
\$400 to \$409.....	3		1	1		1	
\$410 to \$419.....	1			1			
\$420 to \$429.....	2			2			
\$430 to \$439.....	3	1	1	1			
\$440 to \$449.....	3			1	2		
\$450 to \$459.....	2		1	1			
\$460 to \$469.....	1	1					
\$470 to \$479.....							
\$480 to \$489.....							
\$490 to \$499.....	1		1				
Unknown.....	56	12	24	10	4	6	

Monthly rates paid to intermediate care facilities—Massachusetts

Monthly rate	Total ICF's	ICF	ICF in SNH
Total.....	433	405	28
\$210 to \$224.....	17	16	1
\$225 to \$239.....	8	8	—
\$240 to \$254.....	23	22	1
\$255 to \$269.....	52	51	1
\$270 to \$284.....	77	70	7
\$285 to \$299.....	73	64	9
\$300 to \$314.....	47	47	—
\$315 to \$329.....	41	40	1
\$330 to \$344.....	27	26	1
\$345 to \$359.....	20	18	2
\$360 to \$374.....	26	25	1
\$375 to \$389.....	5	5	—
\$390 to \$404.....	4	2	2
\$405 to \$414.....	—	—	—
\$420 to \$434.....	1	1	—
\$435 to \$449.....	1	1	—
\$450 to \$464.....	1	1	—
\$465 to \$479.....	1	—	1
\$510.....	1	1	—
Unknown.....	8	7	1

Daily rates paid to skilled nursing homes, intermediate care facilities, and extended care facilities—May 1969—Ohio

Daily rate	Total	Skilled nursing home	Interme- diate care facility	Extended care facility	Combined facilities		
					ICF in SNH	ICF in ECF	SNH in ECF
Total.....	770	65	504	182	2	10	7
\$7.40.....	130	—	128	—	1	1	—
\$8.25.....	458	65	376	—	1	9	7
\$9.....	182	—	—	182	—	—	—

Monthly rates paid to skilled nursing homes by size of home—Rhode Island

Monthly rate	Total	Number of beds			
		Under 30	30 to 59	60 to 89	Unknown
Total.....	56	18	16	3	19
\$195.....	1	1			
\$200.....			1		
\$210.....					
\$220.....	1	1			
\$230.....	1	1			
\$240.....	6	2	2	2	
\$250.....	2	1	1		
\$260.....	2		2		
\$270.....	2		2		
\$280.....	7	2	4	1	
\$290.....	4	3	1		
\$300.....	4	4			
\$310.....	2		2		
\$320.....	1	1			
\$340.....	1		1		
\$350.....					
\$360.....	1	1			
Unknown.....	19				19

Monthly rates paid to intermediate care facilities, by size of home—Rhode Island

Monthly rates	Total	Number of beds		
		Under 30	30 to 59	60 or more
Total.....	129	114	10	5
Under \$135.....	3	2		1
\$135 to \$149.....	17	17		
\$150 to \$164.....	9	9		
\$165 to \$179.....	11	7	3	1
\$180 to \$194.....	16	14	1	1
\$195 to \$209.....	12	10	1	1
\$210 to \$224.....	10	9	1	
\$225 to \$239.....	12	12		
\$240 to \$254.....	10	7	2	1
\$255 to \$269.....	14	14		
\$270 to \$299.....	7	6	1	
\$300 to \$314.....	5	4	1	
\$315 to \$329.....				
\$330 to \$344.....	1	1		
\$345 to \$359.....	1	1		
\$360 to \$374.....	1	1		

CHAPTER ELEVEN

INSTITUTIONAL UTILIZATION REVIEW MECHANISMS

Background: Legislative Recognition of Need To Prevent Unnecessary Utilization

One of the important provisions which the Congress included in the original medicare law as a control and safeguard on unnecessary and excessive usage of institutional care was the requirement that each participating hospital and extended care facility have a utilization review plan.

Under the law, the utilization review plan of the institution must be applicable to services furnished to medicare patients and provide for review, on a sample or other basis, of admissions, duration of stays, and the professional services furnished. The review is to include consideration as to the medical necessity of the services and the efficient use of health facilities and services. The utilization review is undertaken by either (1) a group, including at least two physicians, organized within the institution or (2) a group (including at least two physicians) organized by a local medical society or other group approved by the Secretary of Health, Education, and Welfare. The statute provides also that the utilization review group must be organized as in (2) above if the institution is small or for such other good reasons as may be included in regulations. The utilization review group should also review long-stay cases and inform those concerned (including the attending physician) when it determines that hospitalization or extended care is no longer medically necessary.

The Finance Committee and the Ways and Means Committee stressed in 1965 that these requirements, if effectively carried out, would discourage improper and unnecessary utilization. The Finance Committee Report (Rept. 404, pt. I, 89th Cong., p. 47) stated:

"The committee is particularly concerned that the utilization and review function is carried out in a manner which protects the patients while at the same time making certain that they remain in the hospital only so long as is necessary, and that every effort be made to move them from the hospital to other facilities which can provide less expensive, but equal, care to meet their current medical needs."

Widespread Failure To Apply Utilization Review

The detailed information which the staff has collected and developed indicates clearly that the utilization review requirements have, generally speaking, been of a token nature and ineffective as a curb to unnecessary use of institutional care and services. Utilization review in medicare can be characterized as more form than substance. The present situation has been aptly described by a State medical society in

these words: "Where hospital beds are in short supply, utilization review is fully effective. Where there is no pressure on the hospital beds, utilization review is less intense and often token."

This widespread failure to effectively apply utilization review results from several factors (each discussed in greater detail below):

(a) The regulations which have been issued on institutional utilization review requirements are not in accordance with the terms and intent of the statute;

(b) Certification of hospitals and extended care facilities for participation in the program have been continued by the State health agencies and the Department of Health, Education, and Welfare, despite the fact that basic statutory requirements have not been met by those institutions;

(c) Many intermediaries under the program have either ignored or been negligent in assuring that institutions have functioning and effective utilization review mechanisms;

(d) The Social Security Administration has made little effort to verify that contracting agents (State health agencies and intermediaries) carried out the terms of their contracts on this point.

Regulations Undermine Statutory Intent

There are passages in the regulations for which there seem to be no support in the statute. For example, the statute provides that the utilization review group shall be established outside the institution in cases where, because of the small size of the institution or other reasons included in regulations, it is impractical for the institution to have an internal staff committee perform the utilization review function. Clearly, this provision was to avoid situations where a hospital with only two or three doctors on the staff would perform its own utilization review. Contrary to the requirement of the statute, however, the Department's regulations state merely that "in smaller hospitals, all of these functions may be carried out by a committee of the whole (medical staff) or a medical care appraisal committee." It is not clear how a utilization review committee of an extended care facility, composed entirely of the two doctors who admit patients to the facility, and who may even own the institution, could effectively review long-stay cases.

While the statute anticipated that the definition of a long-stay case would be defined in regulations,¹ the regulations do not do so. Under the regulations, each hospital and extended care facility decides on its own what shall constitute a long-stay case.

Perhaps the one provision of the original regulations most inconsistent with the intent of the law is that which stated that "at least one member (of the utilization review committee) does not have a direct financial interest in the hospital (or extended care facility)." This provision encouraged conflict-of-interest situations where all but one of the physicians on a utilization review committee might gain financially when beds are kept occupied and unnecessary services provided. Presumably, even a physician without a direct interest could have an in-

¹The statute reads as follows: "For such review, in each case of inpatient hospital services or extended care services, furnished to such an individual during a continuous period of extended duration, as of such days of such period as may be specified in regulations."

direct financial interest. The great majority of replies by medicare intermediaries to an inquiry on this point submitted to them by the staff questioned the propriety of this part of the regulation. As one intermediary put it in a typical response:

"Ideally, we do not feel that any members of a utilization review committee should have a financial interest in the facility. It is difficult to be completely objective when making a decision that may affect the personal pocketbook."

The utilization review regulations were generally described by one intermediary as follows:

"While the regulations require that the written utilization review plan cover several points, they do not establish minimum requirements under each point; these are left wholly to the discretion of the individual institution."

Certainly that discretion would not very likely be exercised contrary to an institution's self-interest.

The regulations were revised effective in 1970. The revision was no doubt made in response to the committee's publicly expressed concern. The staff points out that even the revised regulations still provide opportunity for conflict of interest to exist. No conflict of interest at all should be permitted.

The staff recommends further that the regulations be substantially revised to preclude any other conflict-of-interest situations and that HEW be requested to suggest any statutory revisions necessary to achieve that objective.

Utilization Review Plans Largely Ignored by Institutions

The requirement for a utilization review mechanism is one of several which a hospital or extended care facility must meet in order to be eligible to participate in the medicare program. Each institution must have a written utilization review plan and copies of that plan are required to be maintained by the State health agencies (which perform certification functions for the program) and by the intermediaries. But whether the terms of the plan are actually being carried out is quite another matter and that is the test the law requires to be met. In actual fact, many State health agencies (and intermediaries) know that utilization review plans are not being followed, but they take no action to remove certification or to require that the plan be properly implemented. Based on a sample of hospitals taken in the middle of 1968, the Social Security Administration found:

1. 10 percent of the hospitals not conducting a review of extended stay cases.

2. 47 percent of hospitals were not reviewing any admissions (a basic statutory requirement).

3. 42 percent of hospitals did not even maintain an abstract of the medical record or other summary form which could provide a basis for evaluating utilization by diagnosis or other common factor.

In one State, the health agency conducted a detailed program review in November 1968. Their findings were that *half* of the hospitals and *all* of the extended care facilities failed to perform any sample reviews of cases which were not in the long-stay category (a statutory requirement).

Only recently did the Social Security Administration conduct a nationwide sample study of utilization review plans in extended care facilities. The results are not yet complete, but indications are that failure to comply with the statutory utilization review requirements will be found on an even greater scale in ECF's than the demonstrated poor compliance in hospitals.

The long delay by the Social Security Administration in seeking to determine the extent of compliance and application of these vital provisions of the law may very well be a prime factor in the much-higher-than anticipated utilization of ever-more-costly institutional care and services.

The staff recommends that the Social Security Administration and State health agencies increase their educational and enforcement efforts to assure that hospitals and extended care facilities have operating and effective utilization review plans. Combined with a tightening of the regulations related to utilization review plans such activity should help reduce the case-load and lower the costs of the program, consistent with congressional objectives established in the original law.

Intermediary Failure to Enforce Institutional Utilization Review Requirements

The statute places upon the intermediary as well as the State health agency responsibility for assuring that participating hospitals and extended care facilities effectively perform utilization review.

Available data indicates that in many cases intermediaries are not performing the functions, despite the fact that the Secretary may not, under the law, make agreements with an intermediary who is unwilling, or unable, to assist providers of services with utilization review functions. In addition to the data previously shown which indicates the extent of noncompliance by hospitals with the utilization review requirements, the staff has learned of an extreme case where an intermediary was responsible for assuring performance of the utilization review function for all the extended care facilities in a State. A subsequent survey showed that sample reviews of admission were not being carried out by any E.C.F. serviced by this intermediary. Intermediaries are obviously not performing in many instances a function required by law.

Social Security Administration Failure To Enforce Institutional Utilization Review Requirements

The administrative performance in the area of institutional utilization review leaves much to be desired. The most important deficiencies can be grouped in three areas: (1) the inadequate regulations which have been issued (discussed earlier), (2) lack of administrative direction and follow-through to assure that contracting agents—the State health agencies and the intermediaries—carry out the terms of the statute and the regulations, and (3) failure to produce and furnish to the agents and the providers data useful in effective utilization review.

With respect to the second point, it was not until 1968, 2 years after the beginning of the program, that the Social Security Administration began to collect data on the utilization review activities

of providers of services. Moreover, the data collected are unsystematic and incapable of sound statistical analysis. But even that data indicates widespread noncompliance with the statute by hospitals (e.g. in many cases no samples of admissions were taken and examined). It was not until early in 1969 that collection of similar data was begun with respect to extended care facilities. These data, together with results of survey visits to a sampling of extended care facilities, indicate that the large majority of extended care facilities are not in compliance with one or more of the statutory provisions relating to utilization review.

One of the most effective tools in utilization review involves usage of data about the operations of one hospital which may then be compared with other hospitals or with the same hospital over a different period of time. In the early stages of the program, the Social Security Administration discouraged the intermediaries from collecting such data and furnishing it to the institutions on a regular basis for their use. It indicated that it would be developing such data on a detailed and comprehensive basis and would send the data directly to hospitals and extended care facilities. Unfortunately, the Social Security Administration did not live up to its promises. After more than 3 years of experience under the program the Social Security Administration is just now completing a sample study of utilization of services *in one State*. The agency has altered its position and now permits intermediaries to gather, analyze, and disseminate data useful to utilization review committees.

Possible Changes in Institutional Review Statutory Provisions

In addition to improving administration of the present institutional utilization review requirements, certain legislative or administrative changes might be considered which could further improve the review process. Some possible changes are discussed below.

1. *Where feasible, have the physician positions on a utilization review committee for a particular hospital filled by physicians associated with another hospital:*

One official of a State medical society stated that exchanging doctors among hospitals for this purpose would "take some of the personal bias out of review." It might be argued, however, that physicians from one hospital could hardly be expected to be familiar with the internal operations of a hospital with which they have no other association. They could not, therefore, be expected to contribute effectively to making improvements in procedures. On the other hand, such physicians might very well bring experience and ideas from those other hospitals useful to the hospital for which they perform utilization review functions. Something productive might flower from this "cross-pollination." Alternatively, rather than having the physicians participate in all of the utilization review functions, the physicians from one hospital could be assigned to review only the long-stay cases of another hospital.

2. *Require that utilization review plans for extended care facilities be organized outside the institution, either through a hospital affiliation, the local medical society or the local health departments:*

Most extended care facilities are relatively small proprietary organizations. Many do not have an organized medical staff through which a utilization review committee can be organized. Perhaps the best and most appropriate sources of utilization review committees for most extended care facilities would be the hospitals with which they have agreements for transfer of patients, as well as local medical societies. The staff suggests consideration of a provision that extended care facilities (and small proprietary hospitals) be required, wherever feasible, to establish their utilization review mechanisms through hospitals with which they have transfer agreements (or another hospital) or medical societies. If such arrangements are not feasible, the requirement could be met through arrangements with the local health department serving the area. Of course, it would be expected that facilities having substantially common ownership would not be authorized to undertake review for each other.

3. *By appropriate Federal and State legislation exempt health care practitioners from legal liability for decisions made during required utilization review and medical audit activity:*

Insurers, physicians, and others have indicated to the staff the reluctance of physicians to render critical decisions with respect to patient care provided by another practitioner because of the possibility of being sued. It is understood that ordinary malpractice insurance does not provide protection against such suits. Several States, however, have enacted statutes protecting physicians against suit arising from a utilization review decision.

Implementation of the staff suggestion might assist in more objective and vigorous utilization review and medical audit activity.

4. *Require intermediaries to employ and apply local, regional, and possibly national utilization criteria in evaluating the provision of institutional services:*

A number of intermediaries have developed data indicating normal or average lengths of stay, by principal medical diagnoses, for hospital and extended care. While variations from those norms are not infrequent and are often justifiable, they do provide useful guides to the ordinary length of stay and range of services which will generally be required with respect to a patient with a given medical diagnosis.

The Social Security Administration should undertake to secure from intermediaries information concerning the development and application of utilization criteria of the nature described above. From that information, standard procedures should be developed and their usage by all intermediaries made mandatory.

Data on normal lengths of stay and service requirements in a given area should also be made available to the institutional review personnel in each hospital and extended care facility to assist their efforts.

Consideration might also be given to requiring, where feasible, and on an expedited and informal basis, recertification by the physician, and possibly prior approval by the intermediary, of lengths of stay and services representing substantial departures from norms.

The above procedures might be particularly helpful in resolving the serious problems which have developed concerning determinations of "level of care" of beneficiaries transferred from hospitals to extended care facilities. Intermediaries are to be commended for their review activities designed to assure that extended care payments are made only where the beneficiary requires that level of care—as opposed to primarily custodial, nursing home or skilled nursing home care. However, not infrequently the beneficiary is transferred to the extended care facility on the basis of a physician's recommendation with uncertainty on the part of the facility and the beneficiary as to whether medicare will pay for the care provided. It is difficult, in the absence of appropriate medical data provided by both hospital and physician beforehand, for the extended care facility to make a reasonable determination that the patient it is admitting will be covered under medicare. Possibly relating automatic eligibility for not more than a specified number of extended care days to principal medical diagnoses of hospitalized beneficiaries might help in this difficult area of determination. Particularly, where a patient is discharged from a hospital in less than the normal length of hospital stay for one with his diagnosis, automatic eligibility for a specified number of extended care facility days might be helpful in encouraging early discharge from hospitals to less costly facilities. This would not preclude subsequent determination that extended care was not required; however that care would be covered for the specified number of days or until the determination, whichever came first. Alternatively, wherever feasible, the transferring hospital might be required to submit to the extended care facility and intermediary, prior to transfer of the patient, sufficient data upon which a reasonable determination of need for extended care might be made.

5. *Homemaker benefit as alternative to institutional care:*

Institutional utilization review, ideally, relates the patient's need for continued institutional care in the context of available alternative services. Many physicians and a number of health insurers have pointed out the pressure for continued hospitalization of a patient for several days more than medically necessary because of the lack of someone to assist the patient at home with food preparation, routine cleaning, etc., during the first week or two following discharge from the hospital. During that period, the patient gradually recovers capacity for independent living and ability to meet his routine living needs. In the absence of assistance at home during that recuperative period, physicians are understandably reluctant to discharge patients and patients are reluctant to go home. The present alternative to continued hospitalization is to discharge the patient to an extended care facility or skilled nursing home, which, while less costly than hospital care, is still quite expensive and often encompasses more care than those patients need.

The staff recommends that consideration be given to authorization of homemaker services to a medicare beneficiary where his physician certifies that in the absence of such services continued institutionalization of the patient would be required. While the benefit would be charged against the home health coverage in medicare, a homemaker

agency, distinct from the present "home health agency" employed in Title 18, might be an adequate and less costly alternative to use of a "home health agency."

To avoid abuse and to gain appropriate experience with a home-maker benefit, provision of this coverage might be made available initially on a demonstration project basis. That would enable comparative experience to be measured and costs assessed. Further, at the beginning, and perhaps permanently, such coverage should be limited to the number of days specified by the physician not to exceed a period of 2 weeks.

CHAPTER TWELVE

MEDICARE FISCAL INTERMEDIARIES

How They Are Chosen and What They Do

Under the hospital insurance part of medicare groups or associations of providers of services—hospitals, extended care facilities and home health agencies—can nominate an organization to act as “fiscal intermediary” between the providers and the Government. An individual member of an association or group of providers which has nominated one organization as intermediary may select some other organization as its intermediary if it is satisfactory to that organization and to the Department of Health, Education, and Welfare. Alternatively, each provider can elect to deal directly with the Government.

The Department of Health, Education, and Welfare may not enter into an agreement with any fiscal intermediary unless it finds (1) that it is consistent with “effective and efficient administration,” and (2) that the nominated organization is able and willing to assist providers in the application of safeguards against unnecessary utilization of services. There are provisions in the statute for termination of the contract with an intermediary either at the initiative of the intermediary, or of the Secretary if the intermediary is not carrying out the agreement properly. In the latter case there is opportunity for a hearing.

Most non-profit community hospitals as well as some other types of hospitals, (a total of 6876 out of 7906 hospitals) nominated the Blue Cross Association as intermediary through their membership in the American Hospital Association. Additionally, somewhat more than half of the extended care facilities also selected Blue Cross as their fiscal intermediary. The balance of the extended care facilities selected various commercial insurance companies as fiscal intermediaries. In addition, certain facilities, primarily government hospitals have elected to deal directly with the Government.

The 13 principal intermediaries are paid for the costs of carrying out the functions which they perform on behalf of the Government. Those functions, as set forth in the statute, may be summarized as follows:

- (1) provide consultative services to providers to help them establish necessary fiscal records and qualify for the program.
- (2) serve as a channel of communications between the Secretary and the providers,
- (3) make audits of providers' records, and
- (4) perform other necessary functions specified in the agreement between the Secretary and the intermediary.

The following sections present certain problems and issues related to intermediaries which have come to the attention of the staff.

Problems and Issues in Intermediary Designation

1. Provider Selection of Intermediary—As indicated, each provider of services may nominate the intermediary of its choice where the prospective intermediary and the Secretary of Health, Education and Welfare approve. Some intermediary organizations, in their replies to staff questionnaires and in conferences with the staff, indicated that problems have arisen under this statutory procedure.

For example, one intermediary reported that it was somewhat hesitant to require the hospitals for which it acts as intermediary to do a more effective job of utilization review or to take other steps to control costs, fearing that some of the providers would choose another less critical and more accommodating organization as intermediary. Thus, the intermediary nominating provision, originally intended to furnish assurance to hospitals that they would be dealing with a familiar organization under the new program, may lead to situations which subvert cost control aspects of the program. While there have not been widespread changes in intermediary assignments, the mere threat of change operates in a negative way to dampen positive administration.

Moreover, under this provision it is possible for intermediaries to offer themselves to an institution with the understanding, implicit or explicit, that in return for its nomination the intermediary will give preferential treatment to the institution. We have learned of situations in Florida, Connecticut and in Pennsylvania where the intermediary also began underwriting the casualty and other insurance needs of institutions. Thus, the relationship can be profitable to both the intermediary (despite the fact that it receives no more than costs for its medicare services) and the institution—to the possible detriment of the program and probably to the beneficiaries as well.¹

As another example of this type of situation the Massachusetts Hospital Association is reportedly considering withdrawing its nomination of the Massachusetts Blue Cross Plan as intermediary. A General Accounting Office auditor stationed in that area suggested that the primary reason for the possible change related to the activities of the Blue Cross auditors. He suggested that perhaps the auditors were a little too zealous to suit some hospitals, in assuring that only properly-included costs were paid for. The Social Security Administration has not yet approved the "musical chairs" approach of the Massachusetts hospitals involved, but clearly, the Blue Cross auditors are in a peculiar position when a good job on their part may lead to Blue Cross losing the medicare business.

The staff concludes that the original purpose of the provision for provider nomination of the fiscal intermediary has largely been served and that with the maturation of medicare consideration should be given to modification to avoid the problems discussed above. This could be accomplished by authorizing the Secretary to designate intermediaries under part A as he now selects carriers under part B.

¹ While there would seem to be no incentive for an intermediary to solicit new providers since it receives no more than its costs of operation, there are certain results of obtaining new business which might make an intermediary's own operations more profitable. For example, a higher volume of claims may make worthwhile the introduction of larger, more costly and more sophisticated computer operations with resultant savings in both the medicare and non-medicare operations of the intermediary.

2. *Centralized Intermediary Operation.*—Most non-profit community hospitals nominated the Blue Cross Association as intermediary through their membership in the American Hospital Association.² The Blue Cross Association in turn seeks to coordinate the efforts of the many local Blue Cross plans who actually function as intermediaries. The Association considers the local Blue Cross plans as its subcontractors.

The system which the Blue Cross Association established and is expanding as intermediary has been criticized as an additional, artificial, costly, duplicative, and sometimes unnecessary layer of administration. While it may enhance the BCA position in relation to its 75 local member plans, it also seems to have impeded effective and efficient operation of the hospital insurance program. Social Security regional personnel have advised the staff that they are often limited to only the most routine of inquiries in dealing with local Blue Cross plans—that everything else must be routed through the Chicago headquarters of the Blue Cross Association.

No local Blue Cross plan has been rejected by the Blue Cross Association for medicare as being too small or inefficient. The administrative capacity and performance of the subcontractors range widely yet the Social Security Administration has so far, taken the good with the bad under this "all or none" prime contract arrangement.

The Bureau of Health Insurance should, in any subsequent contracts with the Blue Cross Association, reserve and exercise the right to select as local intermediaries *only* those Blue Cross plans which are capable of proper and efficient performance. Social Security regional offices should also have authority to deal directly with local Blue Cross plans in medicare matters without the necessity of routing all but the most nominal inquiries through the Chicago offices of the Blue Cross Association.

Intermediary Performance Varies Widely

The staff analyzed detailed workload data for the first quarter of 1969, comparing various measures of intermediary performance. These data were provided by the Social Security Administration in response to specific requests by the staff. Those data revealed the following information:

1. Processing time for inpatient hospital bills (the average number of days between date forwarded for payment and the date approved for payment) varied from a low of 2.5 days to a high of 25.3 days. The average was 12.1 days.

2. The proportion of bills returned to intermediaries by Social Security because of error varied from 1.1% to a high of 31.8%; the average was 5.2%.

3. The proportion of bills pending with the intermediary for 30 days or more ranged from a low of zero to a high of 92.3%; the average was 12.9%. Five intermediaries had ratios of 50% or more.

4. There was, as might be expected, a marked tendency for an intermediary to be either above or below average on these measures of performance rather than low on some and high on others. For

² The American Hospital Association owns the rights to and licenses use of the Blue Cross symbol.

example, one intermediary had 45.2% of its claims pending over 30 days (national average 12.9%); average processing time was 25.3 days (national average 12.1 days); and proportions of bills returned to that intermediary by Social Security because of error was 17.9% (national average 5.2%). Similarly, when an intermediary was above average in performance on one measure it was also likely to do better than average on other measures; for example, one intermediary had 9.2% of its claims more than 30 days; average processing time was 7.2 days; and the error rate was 2.6%.

From these facts it can be concluded that there is an extremely wide variation in the levels of performance of the intermediaries.³ The performance of some appears so much below average that serious consideration of replacement by a better performing intermediary seems called for. This process would, of course, be facilitated if the intermediary nominating procedure were modified as the staff suggests.

Conflict of Interest

The staff discovered a situation where the official employed by an intermediary to head up its medicare operation, also served on the board of directors for a chain of nursing homes for whom the insurance company might have acted as intermediary. (This official has since resigned his directorship.) The staff does not know how widespread this or similar practices may be, nor what specific effects such situations may have on the program. The possibilities, however, seem clear.

In addition, the staff has found cases where the intermediary has been made the underwriter of an extended care facility's insurance needs at the same time that it became intermediary for that institution. Moreover, the staff was informed by one Blue Cross plan that in some cases an intermediary organization lends funds to build or add on beds, becoming the mortgagor to the institution it services as intermediary. Depreciation is reimbursable under medicare on assets acquired with borrowed funds. Interest on debt is also a reimbursable item. Obviously, the intermediary who made the loan to the provider in the first instance would have more than a casual interest in seeing that the medicare reimbursement which it approved for that institution was adequate to service the debt owed to it.

To date, the Social Security Administration has not taken the steps necessary to determine precisely how extensive such arrangements as these may be, nor their possible effects on the integrity of the administration of the program.

A serious conflict of interest situation is also created where Blue Cross plans, acting as subcontractors under the program, have a "carve-out" reimbursement arrangement with hospitals. Under this arrangement the Blue Cross subcontractor first determines the amount the hospital should be paid by medicare and then, based upon remaining costs, pays the hospital on behalf of its regular Blue Cross subscribers.

There is, therefore, an incentive, in such cases, for the Blue Cross subcontractor to maximize the medicare payment since that procedure would reduce its own payments to a hospital.

³ Appendix G, p. 271 contains detailed tables on intermediary performance.

CHAPTER THIRTEEN

MEDICARE CARRIERS

How They Are Chosen and What They Do

Under part B of medicare the Secretary of Health, Education, and Welfare is authorized to enter into contracts with carriers to perform certain functions involved in the administration of the medical insurance part of the program. Among the functions which the carriers are authorized to perform are the following:

(1) process claims for payment and make payment for services covered under the program,

(2) receive, disburse and account for funds in making such payments, and

(3) serve as a channel of communications of information relating to administration of the program between the Secretary and those furnishing services covered under the program.

The intent of Congress with respect to the selection of and evaluation of the performance of carriers was expressed in the Report of the Committee on Finance on the medicare legislation (Report 404, 89th Congress, 1st session, p. 54) in the following terms:

"The Secretary shall, to the extent possible, enter into a contract with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance."

As in the case of fiscal intermediaries under the hospital part of the program, the carriers are reimbursed for the costs of carrying out the functions they perform, and (also as in the case of intermediaries) a contract with a carrier can be terminated by the Secretary, after opportunity for a hearing, if he finds that the carrier has not fulfilled the terms of its agreements. Contracts with carriers are generally for a term of one year and are automatically renewable unless notice of termination is given 90 days before July 1 of each year. Unlike the procedure applicable to intermediaries, however, the Secretary can decide not to renew a contract with a carrier without making a finding that the carrier has failed to carry out the contract and without a requirement for a hearing. The following sections deal with several issues and questions relative to carrier performance.

Evaluation of Carrier Performance

Carrier Data Not Collected

The clear intent of the language in the Finance Committee Report quoted above is that, after experience with a variety of carriers, the Secretary would compare performance and then after complete evaluation of all pertinent data, decide which carriers to retain and

which to terminate. It is evident at this point that little action has been taken to weed out and terminate the inefficient carrier. While the Department contracted with a large number and variety of carriers, it seems to have carried out very little objective analysis of the relative administrative performance of the carriers until recently. In July 1968, the staff requested specific data on the performance of carriers with respect to a series of objective measures of performance. Surprisingly, virtually none of the data were then available in the Social Security Administration (after two years of program operations) and had to be developed to meet the staff request. More than five months elapsed before this elemental and basic data could be compiled and arranged in the order of ranking requested by the staff.

The objective information finally assembled by the Social Security Administration and furnished to the Committee indicated wide variations in levels of performance among the carriers. The staff had requested data on 16 separate items relevant to an evaluation of carrier performance.¹ When transmitting these data the Commissioner of Social Security indicated, with good reason no doubt, that there were other measures of carrier performance which were not susceptible of statistical analysis. As examples he gave the following: "the application of the requirement of the law and regulations to the processing of medicare claims, including effectiveness in the application of criteria for the determination of reasonable charges; carrier responsiveness to inquiries and to other needs for service and help, as indicated by beneficiaries and our field organization; and the establishment of effective relationships with the medical community."

When the carriers are evaluated in some depth on these additional factors there is still noted wide variation and low levels of performance. For example, with respect to the first item mentioned by the Commissioner—compliance with the requirements of the law and regulations—the Social Security Administration conceded in official instructions as late as February 1969 that many carriers did not yet have the individual physician charge profiles necessary to carry out the regulations.

One of the basic factors relevant to an evaluation of this element of carrier performance would be the extent to which patients sought Social Security district office assistance in pursuing their claims with the carrier. Unfortunately, the Social Security Administration does not have data (but could easily collect it) on the number of beneficiary inquiries about specific medicare claims which are handled by the Social Security district offices in each carrier area. It is not clear, then, on what basis carrier performance in this respect is evaluated by the Social Security Administration.

The Commissioner did agree, however, that the data requested by the staff was relevant to evaluating carrier performance. The Commissioner made this point by referring to these data as "the principal statistically measurable indications of carrier performance available."² The practice used in evaluating carrier performance is de-

¹ The staff was well aware that no single criterion, or even two or three, could give an accurate picture of a carrier's performance. For example, it was understood that a very low cost-per-claim processed might result from an administrative philosophy of paying all claims without question, as much as from efficient procedures. Thus, a high-cost carrier could be doing a most efficient job.

² These comparative performance and costs data appear in appendix H, p. 281.

scribed in the language of the Social Security Administration: "A non-mathematical composite view of performance has been used in the past to judge how well each carrier is meeting its contractual obligations and we are now developing (as of December 1968) a master index of carrier performance."

Carrier Contracts Renewed Virtually Automatically

What has occurred to date may be summarized as follows: The medicare program entered its fourth year on July 1, 1969 and during the prior three-year period the Bureau of Health Insurance renewed virtually all carriers automatically for the full 1-year period in each year. In only one case was a carrier renewed for a shorter six-month period with further extension contingent upon meeting specified performance requirements. In another case the contract was renewed but with agreement to reservation of the right of the Government to reduce the geographic area assigned if specific improvements in performance were not attained. In December 1969 the California Blue Shield plan's geographic area was, in fact, reduced. Five other carriers have been told that contracts would not be renewed unless specific deficiencies were corrected. These other carriers had their contract renewals made contingent upon effective application of the criteria for determining reasonable charges.

The staff does not suggest that information available to the Social Security Administration (e.g. survey visits, internal audit reports) are not useful in evaluating carrier performance—they are, of course. But it does believe that much of the very basic data it requested that previously were unavailable should be maintained on a continuous basis and should serve as a substantial part of the core of information used in carrier performance evaluation.

Since none of the poorly performing or inefficient carriers have been dropped from the program at the initiative of the Secretary (one carrier voluntarily withdrew from the program; but it was *not* one of the poorer performing carriers), the staff concludes that the Congressional intent has not been carried out in at least two respects. First, there has been no active policy of complete and in-depth comparison of carrier performance followed by decisions to weed out the poorer carriers in favor of those who are efficient and economical. As indicated, variations in performance are so great as to make at least some terminations easily justified. Second, the performance of some carriers has been so poor that there is little question that their performance was "inconsistent with the efficient and effective administration" of the supplementary medical insurance program.

Inefficiency Subsidized

Unquestionably many millions of dollars have been paid in the form of subsidized inefficiency. Some of this expense was unavoidable but much of it could, the staff believes, have been avoided through alert, aware and prompt action by the Social Security Administration. While many millions of dollars invested in inefficient carriers, thus far, would be lost through termination, the staff believes that the government (and the older citizens whose premiums pay half of those costs) would gain far more in the long run through "cutting losses" now.

What appears needed are fewer carriers and a benefits and administrative structure lending itself to genuine competition for the job of

medicare agent. Carriers can then concentrate primarily on utilization review rather than elaborate payments procedures. Carriers might be compensated on other than a costs basis to induce the best health insurers to undertake Part B functions. Conceivably, in addition to straight administrative costs, incentive payments might be available related to combined factors of utilization of services, unit costs of services and administrative costs.

***Some Blue Shield Plans Balked at Providing Program Data to Government:
The Issue of Public Accountability***

The majority of the Part B carriers are Blue Shield plans. Blue Shield, known as "the Doctors' Plan," is organized and controlled by physicians. Such organization and control is not inappropriate but has, it is apparent, created questions for Blue Shield as to whom it is accountable and whom it represents when it functions as an agent of the Federal Government in administering Part B of medicare. Perhaps Blue Shield is and should be concerned about its obligations to physicians in the operation of its regular business. However, it has additional obligations to the Government when it functions as medicare agent. Those requirements stem from considerations of public accountability which arise when a non-governmental agent is entrusted with billions of dollars in public funds.

When public monies are paid out by a Blue Shield plan—or any other carrier or fiscal agent—the Government has the right, in fact, the duty, to be advised by the agent as to how those funds were disbursed. These include the names of those to whom medicare (or medicaid) payments were made, the amounts paid, and the various components of payment.

In this context, it was distressing and almost inconceivable, that a fair number of Blue Shield plans initially refused to comply with that part of the Social Security instruction in response to a staff request that they identify, by name, physicians who had been paid \$25,000 or more by medicare in 1968. Most of those plans which declined, at first, to provide the information requested, said that they had not been "authorized to do so by the physicians involved."

Clearly, the issue raised did not involve "authorization" by physicians. The staff could find no provisions in law, regulation or carrier contracts which provided that identification would not be made to the Federal Government except with express physician "authorization."

The underlying concern of those Blue Shield plans which resisted providing names is understandable. Blue Shield works with and depends upon the goodwill of physicians for much of the success it enjoys in its regular day-to-day business where in most instances it actually contracts with individual doctors. In medicare, however, the contract is with the United States Government. The Government's obligation is to undertake such procedures as will assist in assuring its citizens—particularly the millions of elderly who pay premiums—that their money is being properly expended. The Government is "trustee" of the part B trust fund.

The staff stresses that its concern is with the basic issue of public accountability—not with any advocacy of publication of the names of individual physicians and the amounts paid them. Legitimate arguments—pro and con—need careful consideration prior to any decision to take such a course.

CHAPTER FOURTEEN

THE QUALITY OF ADMINISTRATION OF MEDICARE

As indicated earlier, most of the everyday activities in processing claims and dealing with providers of health services are handled by private organizations and State agencies under contract with the Federal government. An evaluation of the Federal government's role should appropriately focus on two key aspects—(1) the methods by which the Government communicates policy and other information to its agents and how they transmit it to the provider and (2) the methods by which the Government informs itself about the performance of the contractors and emerging problems. As one method of evaluating the first function the staff questionnaire sent to the carriers and intermediaries of the program specifically asked them to evaluate the quality of instructions and other material which they received from the Social Security Administration as either "poor," "fair," or "good." Specific recommendations concerning means of improving the material were also requested.

The responses of the intermediaries were as follows:

Poor -----	4
Fair -----	27
Good -----	46

Responses from the Part B carriers were:

Poor -----	2
Fair -----	19
Good -----	30

Almost all of the carriers and intermediaries offered specific comments and suggestions—many detailed and thoughtful. The most recurrent responses can be grouped roughly as follows:

- (a) instructions are not timely and should not be given to providers of services before submission to intermediaries,
- (b) instructions are too voluminous and detailed, and
- (c) instruction should be written more clearly and simply and should include examples.

The staff has furnished the comments (unidentified as to source) to the Social Security Administration for their use in improving their instructions. The staff recommends to the Committee that it urge the Social Security Administration to make a major effort toward greater clarity and simplicity in their instructions to intermediaries and carriers.

Apart from carriers, intermediaries, health agencies, and providers, Bureau of Health Insurance instructions (including technical materials) explanatory of the program's policy, operations, and areas of concern should be given the greatest possible dissemination, with the

least possible impediments to availability, to all directly or indirectly concerned or interested in medicare. The extent to which this objective can be achieved will undoubtedly be reflected in greater understanding, cooperation, and support of the program—apart from stimulating the kinds of constructive criticism which might generate improved performance.

Program Evaluation and Research Activities

One of the more important elements in appraising administrative performance is the quality of the research and program evaluation effort. One of the most important uses of program statistical data—sound cost estimating—deserves special mention.

The assessment of this aspect of the research effort can perhaps be best accomplished by examining the contribution which program data have made to the cost estimates for inpatient hospital care—the benefit with the largest cost. There are essentially two elements which make up the cost of this benefit—(1) the number of inpatient hospital days used by beneficiaries and (2) the cost in dollars of a day of covered care.¹ Given these two figures, it is easy to determine the total cost for a given number of beneficiaries.

As of the beginning of the program, of course, assumptions about hospital utilization and per diem costs were based on the experience of other programs and related data. Even as late as the end of 1967 (at the time of congressional passage of the 1967 Social Security Amendments) the cost assumptions upon which the estimates were based could not be verified by actual program data since those data were not available, even though the program had been in actual operation for almost a year and a half.

The assumptions of per diem costs were raised at that time (with a consequent increase in the estimated costs of the program) but they were based, in part, on the statements of the Blue Cross Association and the American Hospital Association rather than actual program data. By the end of 1968 some data about utilization of hospitals by the beneficiaries of the program for the first 18 months of the program had finally become available and were used to revise upward the estimated cost of the program. However, complete program data on actual costs per day were still not available. Thus the cost estimates still are not based on program experience and only utilization is based on any program figures. The estimates may be low or high; it cannot with any certainty be said which. The reasons for the lack of program data for use in supporting the estimates was summarized as follows by Social Security's Chief Actuary:

In theory, the data available from the operations of the medicare program are adequate for making the necessary actuarial cost estimates. In practice, however, certain difficulties have arisen—namely, (1) long delays in submission of bills by providers of services, principally hospitals, (2) long delays in handling of bills and payment records by fiscal intermediaries and carriers, (3) the great amount of time

¹ There are other elements such as the effect of deductibles and coinsurance provisions but these are computed after the basic estimate is made.

involved in completing final cost settlements that are on a reasonable-cost basis, and (4) the excessive amount of data that are collected for "research and statistics" purposes, which has the effect of significantly slowing down the administration of the program and of delaying tabulations of actuarial and operational data.

Therefore, in addition to the delay in securing data arising from the fact that so few hospital accounting periods have been finally settled, the present difficult situation arises from an ineffective and cumbersome health insurance research effort.

The staff concludes that the present health insurance research and program evaluation effort needs to be substantially revised. In this connection the following suggestions are made:

(1) Health insurance research directly related to day-to-day evaluation of program administration should be given the highest priority and should be placed in the Bureau of Health Insurance as an administrative control under the authority of the Director of the Bureau of Health Insurance.

(2) Program data useful for cost-estimating purposes should be given a priority only slightly lower than program evaluation data and should be designed and analyzed by the Office of the Chief Actuary.

(3) Health insurance research related to the impact of the program on beneficiaries and the health industry should have the next priority and should be carried out, as now, under the direction of the Office of Research and Statistics.

(4) Contractors with the program—carriers, intermediaries and State agencies—should be relieved of as much data-gathering and report-making as possible consistent with the objectives of the research and should be the regular recipients of analyses of data which might be useful to improvement of their performance.

CHAPTER FIFTEEN

MEDICAID ADMINISTRATION

Poor Administration Widespread

There are serious and costly deficiencies in the operation, administration and supervision of the medicaid program. The typical medicaid patterns are slow payment to suppliers of health care goods and services; little effective effort to determine whether those goods or services were necessary (or even given); little or no control over recipient abuse; and, general laxity of administration. Findings of the HEW Audit Agency, reviews of State programs made by the Medical Services Administration (the HEW agency responsible for overseeing medicaid), General Accounting Office reports and those of various individual State agencies, as well as staff conferences with State legislators, administrators, and others—all underpin the negative conclusions of the staff.

A detailed summary of medicaid shortcomings in 16 States is contained in a report prepared by the HEW Audit Agency, a part of the Office of the Secretary. That report is reproduced in full as Appendix C, p. 201. In the covering letter of August 26, 1969 forwarding the report to Miss Mary E. Switzer, Administrator of the Social and Rehabilitation Service (of which the Medical Services Administration is a component arm), the Audit Agency said:

The report shows the existence of widespread administrative problems which require prompt action by both the States and SRS if program objectives are to be achieved efficiently and economically. Problem areas of most concern centered on: (1) duplicate payments, excessive rates and fees, and other types of erroneous charges which would not have occurred if adequate management control had been established over claims submitted; (2) the lack of systematic reviews of utilization of service; and (3) the need for improved procedures in determining eligibility and operating Quality Control programs * * *.

Insofar as SRS regional and headquarters operation of the program is concerned, recommendations included in this report call for a current reexamination of resources utilization and capability with a view toward staff expansion and strengthened administrative controls (to some extent this has already been acted on). Also recommended are improvements with regard to (1) lack of effective followup on deficiencies disclosed by Program Review and Evaluation Projects; (2) untimely issuances of guidelines needed to clarify the requirements of amendments to the Act; and (3) the need for a more clearly defined mission and responsibility of the field administration.

HEW Official Concedes Costly Shortcoming

Top officials in the Department of Health, Education, and Welfare have become increasingly aware of the dimensions and specifics of the difficulties pervading the medicaid program. At the Committee's hearing on July 1, 1969, the Under Secretary of HEW, Mr. John Veneman, said:

I would like to mention to you very briefly the results of an audit report on medicaid that we have received from 10 States. I think that they have been submitted to the committee.

We anticipate that we will have audit reports from six additional States by the end of the month.

The audits demonstrate the existence of rather widespread administrative problems and the necessity to have some immediate action to protect the program objectives. I have just outlined one of the problems that the audit reports reveal.

Another is the matter to which Mr. Constantine referred, of duplicate payments, indications of excessive rates, excessive fees, other types of erroneous charges that have been made to the program, and again, the glaring thing is lack of adequate management controls by the States, or their agents over medicaid claims made by some nursing homes, pharmacists, and others.

The second thing the audit reports revealed is that systematic review of services is not being made. I think one of our requirements in the title XIX program is that there be an accurate and specific procedure for utilization review as part of the State plans.

There were noted incidences of excessive drug refills and overutilization of services.

The audits also noted the need for assuring that the payments are only being made to those who are eligible. They revealed that in some cases, the identification cards were being utilized by persons who had not met or been deemed eligible for the program. A good deal of the expenditure of public funds depends upon the reliability of the eligibility standards. Mr. Kelly is with us today and he can further elaborate on the audit reports if you desire at a later time.

Later that same day, the following exchange occurred between Senator Jordan of Idaho and the Under Secretary:

Senator JORDAN. Now, with respect to medicaid. Our staff review made this statement, and I would ask you to comment on it.

"Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs, and States have been unwilling to assume the responsibility on their own. The Federal medicaid administrators have not provided States with the expert assistance necessary to establish and implement proper control. Also, they have not developed mechanisms for coordination and communication among the States about methods of identifying and solving medicaid problems."

Now, I think the Secretary said in his opening statement that medicaid, probably had to deal with 44 different States and all the different or regional differences among some of them. But what is your answer to this charge?

Mr. VENEMAN. I would agree with the charge, Senator.

Senator JORDAN. You agree with it?

Mr. VENEMAN. Yes.

Senator JORDAN. What can we do about it?

Mr. VENEMAN. One thing we have to do immediately is make sure we have compliance with State plans, that the State plans do carry out the intent of the legislation. I think anything of this nature is somewhat inexcusable, but I think that it is understandable. When several States have initiated and adopted programs of the magnitude of title XIX medicaid, there are bound to be some problems in the first couple of years.

Need for Federal Leadership

Various recommendations are contained in the following section which the staff believe might serve as a basis for Committee consideration of methods of improving medicaid. However, there is another key element which is essential if the program is to function as intended. While the Medical Services Administration probably requires additional personnel if effective Federal supervision of medicaid is to be realized, it appears vital that any additional personnel—including officials—operate with a greater sense of responsibility and direct involvement than has been manifested heretofore. The Medical Services Administration needs dynamic, concerned, and qualified leadership and staff if a complex, costly, and important program such as medicaid is to be soundly administered.

Recommendations for Improvement—Medicaid

Requiring Use of Fee Schedules

The staff recommends that consideration be given to mandating usage of fee schedules for payment of health care practitioners under medicaid.

In this context, States might employ scheduled allowance contracts presently held on a broad basis by Blue Shield or other third-party policy-holders in a given State or portion of a State. The staff assumes in making this recommendation that the Congress did not intend to pay more for care provided to the indigent and medically-indigent than private health insurers generally allow under their most widely-held contracts or policies for their insured members who are part of the working population.

If fee schedules are ultimately employed as a means of fixing medicare liability, such schedules might also serve, in modified form, as bases for payment under State medicaid plans.

Cut Drug Costs

Require that drugs be provided on substantially the same basis which would have been established under the provisions of the medicaid amendment adopted by the Senate in 1967. That provision, sponsored by Senator Russell B. Long, would establish a formulary of the United States, with drugs deemed appropriate for inclusion determined by a

high-level qualified formulary committee. Federal matching would be limited to the amounts charged for lower-cost products of each drug in the formulary which were determined to meet all official standards and to be of proper quality. Exceptions to the limitations could be made upon a satisfactory showing that a particular higher-cost product had "distinct, demonstrated therapeutic advantages" over the lower-cost products of the same drug or where a physician prescribed a drug product by its official or established name and the name of its manufacturer.

In accordance with a section of the Social Security Amendments of 1967 which called for a study of the proposal by the Department of Health, Education, and Welfare, a report was submitted to Congress in January 1969 by the Department's Task Force on Drugs recommending adoption of the basic provisions of the "Long Amendment." If that recommendation is followed, many millions of dollars in prospective medicaid drugs expenditures should be saved.

Curb Overutilization Through Prior Approval of Certain Services

States should adopt procedures for prior independent professional approval of elective surgery, dental care (except for minor procedures), eye care, and hearing aids.

The experience of several States indicate that a system of prior approval for selected types of costly health care can be an effective method of controlling utilization and costs as well as avoiding the exposure of recipients to unnecessary hazard and pain.

The New York City "Medicaid Watchdog System" (a description of which can be found in Appendix D, p. 247) is a prototype for this kind of activity. Under that system, dentists are hired by the health department to review plans of treatment and give their approval or disapproval. The administrators of the system claim savings of \$26 million in 1968 in dental care costs alone. Comparable savings were experienced under the prior approval system as applied to optometrists, chiropractors, and podiatrists.

Since the medical or dental procedures involved are not those which generally need to be performed on an emergency or immediate basis, patients should not suffer from the short delay involved in securing the necessary professional approval. A requirement that the review be performed by qualified medical or dental professionals in the health care fields involved would avoid charges of lay interference.

End Costly "Doctor-Shopping" Through Patient Designation of Primary Physician

States should require the designation of a "primary physician" by recipients in areas or cases where abuse of physician services by recipients is detected or where that type of costly overutilization is widespread.

In some States medicaid recipients have engaged in "doctor-shopping." This involves a recipient going from one doctor to another for the same condition, getting a prescription from each physician and not telling the second (or third, fourth or fifth) physician that he has already seen some other physician.

For example, an illiterate elderly couple in Kentucky had 33 different kinds of medicine in their home prescribed by six different physicians. The nightstand in this couple's home contained four nearly-full

bottles of identical pills which different doctors had prescribed. Such situations greatly increase the cost of the program and are wasteful of scarce physician manpower.

Under the recommendation, when a State medicaid agency (or its fiscal agent) anticipates or discovers such a situation, the recipient would be required to make a choice of his primary physician. His medicaid card would then bear the name of that physician and he could not get any covered care—other than in an emergency—except care provided or prescribed by that designated physician. The primary physician, of course, could make referrals to other physicians within the scope of the State plan. Provision could be made for a change in primary physician designation upon notice to the agency in order to preserve free choice of physician. This system should be helpful in deterring overutilization of physicians' and other health services by those recipients who "shop around." It should also help prevent the practice of an eligible recipient lending his medicaid card to an ineligible person for his use. In this case, the "primary physician" might recognize that the ineligible bearer of the card was not his patient.

Detect Abuse by Informing Recipients of Payments Made on Their Behalf

Require that the State furnish each recipient with a notice and explanation of all health care paid in his behalf by the program.

Experience with the detection of abuse and fraud in the medicare program indicates that beneficiary complaints about discrepancies between the "explanation of benefits" form which they receive, and the care actually provided, is by far the largest single source of initial information on abuse and fraud. States should be required to institute similar procedures in their medicaid programs.

In a review performed by the Department of Health, Education, and Welfare of seven of the larger medicaid programs not one was found to furnish information to recipients about the medical bills paid in their behalf, nor were the recipients interviewed to determine whether the services paid for were actually received. In several of those States recipients are not even required to sign the bills or a request for payment form. For example, in an upstate New York county, recipients are not even expected to provide verification of service by signing the bills submitted by providers. Further, recipients are not notified of the medical care paid in their behalf, nor are they checked with to validate the quantity of care they received—not even on a sample basis.

The seven States involved in the survey account for more than one-half of all medicaid expenditures. If California is added to the seven (other information indicates essentially the same situation obtained in that State) the proportion grows to 75%.

Make Practicable Reasonable Cost-Sharing by the Medically Indigent

States should be permitted to impose reasonable deductibles and other cost-sharing devices with respect to the medically indigent (those with incomes or resources above the cash assistance levels) without closely tying the specific amounts of the deductibles to the level of income of the recipient.

Under present law (Section 1902(a)(14) of the Social Security Act) a State may impose a deductible or co-payment feature with respect to the medically-indigent only if the deductible or co-pay is "reasonably related to the recipient's income or his income and re-

sources." The effect of this requirement has been to make virtually impossible the imposition of deductibles or co-pay provisions because of the complexities which result.

For example, a State defines a medically indigent family of four as one having income between \$3,000 and \$4,500 a year (a family with less than \$3,000 in income would be eligible for cash benefits). If this State wished to impose a deductible of \$.75 for each drug prescription for such families it could not do so. Under present law, the deductible would have to vary so that a family with income just over \$3,000 would have a smaller deductible (say \$.50) than a family with income just under \$4,500. To have a drug deductible ranging from \$.50 to \$1.00 would introduce extreme complexity and heavy claims processing costs in the administration of the program.

Pharmacists and recipients alike would have difficulty in determining just what the deductible should be at a particular point in time; moreover, a slight change in family income could affect the amount of the deductible.

The provision in present law purports to achieve equity by requiring those with lower incomes to pay a lower share of the expense. But in actual practice the difficulties are so great that few States have attempted to impose deductibles and other cost-sharing provisions. The result has been that any deterrent effect which such features may have on overutilization are lost to the program as well as any direct savings which might be realized from the cost sharing. While it is difficult to estimate the extent of savings which might result from implementation of this recommendation it would at least reverse one of the effects of present law which undoubtedly accounts for some of the increased cost of the program.

End Payments to Collection Agencies

Prohibit making of vendor payments (under medicare as well as medicaid) to independent collection and bill discount agencies—to anyone other than the person or institution rendering the service.

The staff's attention has been called to the increasing usage by physicians, pharmacists, and some hospitals of independent collection agencies to whom they assign their medicaid and medicare billings.

Apart from the opportunity for fraud and abuse which sanction of such agencies affords—criminal indictments have been handed down in New York in one such case—the costs of using those agencies are obviously indirectly passed on to the program.

Such agencies are employed because they offer to relieve physicians, pharmacists, dentists and others of cumbersome paperwork and provide immediate cash for medicaid due bills which the practitioners might otherwise have to wait months to collect.

The solution, however, lies in streamlining administration and processing—including making timely payment—rather than use of costly and problem-creating outside collection and discount organizations.

Require Federal Approval of State Claims Control Procedures

The claims control system used by a State medicaid system (or by its fiscal agent) should be specifically approved by the Department of Health, Education, and Welfare and if not approved, specific fiscal penalties should be invoked.

Many States do not apply even the most rudimentary claims controls. For example a special survey conducted by HEW staff in December 1968 and January 1969 of medicaid operations in seven different States¹ found only two with systematic methods of avoiding duplicate payments on all health services covered. Only one State had procedures to assure that medical bills were paid only after any resources available to the recipient to pay for the medical care had been expended. None of the States were able to evaluate the medical necessity of the services paid for through analysis of a recipient utilization profile or a provider practice profile. Clearly, States need not only the consultative services suggested but also specific claims control systems approved by the Department of Health, Education, and Welfare. In the interest of standardization of procedures, consideration might also be given to requiring, where appropriate, usage in medicaid of the same utilization review procedures which obtain in medicare.

In May 1969, the Administrator of the Social and Rehabilitation Service advised 15 States² that the written description of the utilization review practices followed in their medicaid programs were not satisfactory. But the somewhat startling fact is that only one of the seven States in the survey previously referred to was in this group of fifteen States. Since none of those seven was actually employing effective utilization review practices apart from the other 14 States the inevitable conclusion is that most States do not have effective utilization review with many not even bothering to develop an acceptable system—even on paper. We would recommend that if a State fails to establish an approved claims control system specified percentage reductions in Federal matching funds should be made.

Improve Federal Administration

Federal administration and supervision of the medicaid program might be strengthened in the following ways:

(a) Consultants with expertise in the fields of claims review and fiscal and professional controls should be made available by the Federal Government to assist any State which requests such assistance. Such personnel could function as a team to assist States in establishing basic operating control programs.

(b) Regulations and guidelines should be reviewed and issued on a timely basis.

(c) Expanded activity to assure that States are fully complying with the Congressional intent respecting the provisions of the medicaid statute.

(d) Special efforts to establish a system of routine and expeditious exchange of information and experience on a formal and informal basis among State medicaid agencies.

(a) Individual administrators of Medicaid programs and other administrative personnel of those programs have complained that the Department of Health, Education, and Welfare does not have the present capability of supplying them with experts in various vital aspects of the program. States—particularly smaller States—need such help to improve basic administration and operation of their programs. HEW's medicaid administration appears to have been content

¹ Ill., Mass., Mich., N.Y., Pa., Wis., Tex.

² Ga., Idaho, Iowa, La., Mass., Minn., Nebr., N. Mex., Nev., Ohio, S.C., S. Dak., Utah, Wyo.

to operate primarily by determining for States whether what they include in their formal State plans for medicaid meets Federal requirements.

What appears needed is far more than this sort of de jure evaluation of compliance with Federal law. A positive and cooperative program of making available Federal experts who can provide detailed concrete suggestions and assistance for improving administration of the various State programs is necessary.

(b) A common complaint expressed by Governors in response to the staff questionnaire was the delay of months and sometimes years in getting regulations and guidelines from the Department of Health, Education, and Welfare. In many cases regulations are promulgated after the statutory effective date and often allowing only a short time for the States to act to meet the new regulation.

(c) The number of onsite reviews of medicaid programs is few and the length of time between reviews is too long. For example, the next HEW review of the New York City program is two years away, despite the fact that New York City spends some 20% of all medicaid money.

(d) Various medicaid programs have developed or tried new techniques of operation and administration. There is, however, no systematic way in which one State can learn from the experience of another State. This rather obvious need for regular informational exchange among the States has not been met by the Department of Health, Education, and Welfare.

Establish New Medicaid Fraud and Abuse Unit

A medicaid fraud and abuse unit should be established in the Department of Health, Education, and Welfare in order to facilitate and coordinate both State and Federal efforts toward the prevention or discovery and prompt investigation, prosecution, and other follow-up activities designed to curb and punish fraud and abuse. This medicaid unit should specifically and formally coordinate its activities with its counterpart in the Social Security Administration concerned with fraud and abuse in the medicare program.

The medicaid fraud unit should also routinely have available to it all medicaid and medicare data bearing upon actual or potential fraudulent or abusive activities. Such data should also be regularly available to the States to assist their enforcement efforts.

Federal administrative responsibility for the medicaid program is now assigned to the Medical Services Administration (MSA) in the Social and Rehabilitation Service of the Department of Health, Education, and Welfare. MSA has no one assigned to the area of fraud. Present MSA philosophy seems to be that discovery and prosecution of Medicaid fraud is entirely a State matter, despite the fact that the programs are funded between 50% and 83% from the Federal treasury.

The Department of Justice believes that fraud in Medicaid now comes within the purview of Federal statutes dealing with fraudulent claims and has indicated its willingness to prosecute such cases. However, in order to support that activity, an active investigative unit is required. The medicare program, administered by the Social Security Administration, has an effective unit, staffed with trained professional investigators, which might serve as the prototype for a medicaid unit.

One of the most effective deterrents to fraudulent activity and abuse is a vigorous program of detection and investigation. That vigor is rarely found in the medicaid program today.

Moreover, the staff has found instances where a medicare fraud case also involved medicaid but where there was no activity in the medicaid area. For example, a doctor in Texas subject to indictment for allegedly submitting fraudulent claims under the medicare program in the amount of \$101,000 also received many thousands of dollars in medicaid payments. Yet, there seems to have been no investigation to determine whether any of his medicaid claims might be fraudulent. Such obviously uncoordinated and unacceptable situations need to be corrected through a coordinated system of handling such cases.

Require State Fraud and Abuse Control Units

Require all States to maintain specific organizational units for the prevention, detection, and investigation of abuse and fraud in their health care programs.

Some States have active programs of fraud and abuse prevention and detection while others have little or none. This is illustrated by the fact that some States with quite large medicaid programs report little or no fraud while other States with comparable programs report many cases. It is quite likely that the former States do not report cases because they have no organized means of investigation or detection. For example, the States of California, Maryland, Pennsylvania and New York are among those which make at least some organized effort to curb and detect fraud and other abuses in their medicaid programs.

Many other States seem to make little effort. In Massachusetts, for example, the program's claims control system seems to be so weak that abuse to a very serious degree went undetected and unchecked. Put simply, those States which report many fraud cases may actually have less fraud overall than those States which report few cases where little effort is made at detection and where program administration is so weak that they virtually foster fraudulent activities.

Under present law, the Federal Government pays 50 percent of ordinary medicaid administrative costs and 75 percent of compensation or training expenses of professional medical personnel and direct supporting staff.

To assist and encourage States to establish comprehensive and professionally staffed utilization, fraud and abuse investigation, cost review and medical audit units, the staff recommends that consideration be given to increasing Federal matching to a flat 90 percent for personnel engaged full-time in such activities. The 90 percent rate should apply only to those professional personnel (doctors, dentists, etc.) and direct support staff who are employed full-time in utilization or cost review work. Of course, costs attributable to physicians and others hired on a part-time basis to perform utilization review whose total time involves control activity should also be subject to the incentive matching rate.

Consolidate Advisory Groups

The 21-member Medical Assistance Council should be terminated and its functions combined with those of the Health Insurance Benefits Advisory Council (HIBAC) which now advises on medicare. The combined advisory group, which might be called the "Medicare-

Medicaid Advisory Council" with total membership not exceeding 21, should be responsible to the Secretary of Health, Education, and Welfare.

The Medical Assistance Advisory Council was established under the Social Security Amendments of 1967.³ Much of its areas of concern and organizational representation overlap those of HIBAC. The principal differences are that the Medical Assistance Advisory Council is concerned with State medicaid programs which vary in terms of eligibility requirements and covered health services, while medicare operates with a uniform national program and eligibility. But, the similarities between the two programs are considerably greater and more important than the differences. Both are concerned with hospital, medical, and related care (skilled nursing home care in medicaid and extended care in medicare), as the major and most costly items of service provided. Patterns of payment and standards of care are related between the programs. A single advisory group would avoid duplicative activity and lend greater focus to and coordination in treating common concerns. A subcommittee approach might be the appropriate method of attending to those areas peculiar to medicaid.

Adoption of the above recommendation should enhance communication and coordination between the two principal Federal programs involved in the financing of health care.

³ The staff also call the attention of the committee to the fact that the present composition of the membership of the Medical Assistance Advisory Council is probably violative of the explicit requirements contained in section 1906 of the Social Security Act. With respect to MAAC membership, the statute states:

"The members shall include representatives of State and local agencies and nongovernmental organizations and groups concerned with health, and of consumers of health services, and a majority of the membership of the Advisory Council shall consist of representatives of consumers of health services." (Emphasis supplied.)

Of the 21 members, only four might possibly be characterized as "representatives of consumers of health services":

1. Dorothy M. DiMascolo, sergeant-at-arms of the National Welfare Rights Organization.
2. Margaret E. Mahoney, executive associate, the Carnegie Corp.
3. Rev. Robert J. McEwen, S. J., chairman, Department of Economics, Boston College.
4. Louis Rolnick, national director, Welfare and Health Benefits Department, International Ladies Garment Workers Union.

The remaining 17 members, listed below, are "representatives of State and local agencies and nongovernmental organizations and groups concerned with health . . ." As will be noted they represent physicians, dentists, State and local governmental agencies, nursing homes, hospitals, and an accounting firm which does a substantial amount of audit work for health care facilities:

1. Donald C. Smith, M.D. (Chairman), Professor of Maternal and Child Health, Univ. of Mich.
2. John Affeldt, M.D., medical director of the California Department of Charities.
3. Roy E. Christensen, Pres. and Chairman, Beverly Enterprises (a convalescent hospital chain).
4. Thomas W. Georges, Jr., M.D., Pennsylvania Secretary of Health.
5. Sam Grais, Chairman, St. Paul and Ramsey County Welfare Board.
6. Kenneth J. Holmquist, hospital administrator, St. Paul, Minn.
7. Amos N. Johnson, M.D., past president, American Academy of General Practice.
8. Marcel Learned, partner in the firm of Ernst & Ernst (he is a specialist in hospital auditing procedures).
9. David O. Maxwell, Secretary of Administration and Budget, State of Pennsylvania.
10. Elmer M. Smith, M.D., director of Bureau of Medical Services, Dept. of Social Services, State of Iowa.
11. Phillip D. Weaver, M.D., Chief of Radiology, Weld County General Hospital, Greeley, Colorado.
12. Maynard I. Shapiro, M.D., past president, American Academy of General Practice.
13. George W. Slagle, M.D., private practitioner, Battle Creek, Mich.
14. Eddie G. Smith, D.D.S., practicing dentist, Washington, D.C.
15. Faustina Solis, Farm Worker's Health Services, State of California Dept. of Health.
16. Edward Walker, President of the American Nursing Home Association.
17. George K. Wyman, Commissioner, New York State Dept. of Social Services.

CHAPTER SIXTEEN

OTHER AREAS OF ACTUAL AND POTENTIAL ABUSE IN MEDICARE AND MEDICAID

Tremendous Growth in Chain Operations

Concern has been expressed by many existing health care institutions and others over the tremendous growth in chain operation and construction of medical facilities and their acquisition of related companies.

Senator John Williams stated on May 14, 1969 (Congressional Record, p. S5202) :

Since medicare started there has been a remarkable increase in the number of chains entering the for-profit hospital and nursing home field. These groups, whose stocks have soared to unbelievable price-earnings ratios, are obviously lured by medicare's generous reimbursement. The 1½ percent bonus paid on top of reimbursable costs, the prospect of getting accelerated depreciation allowances and then selling a facility at an inflated price, the fact that medicare will pick up all of the costs of a 100-bed facility even if its total patient load consists of just five medicare beneficiaries, the fact that there is no effective review of the utilization of beds and services in these facilities, and the fact that the nursing home or hospital can choose the Government agent who will determine how much it is to be paid have certainly encouraged the get-rich-quick operations.

Furthermore, if a chain owns an extended care facility as well as a hospital it can see that patients go from its hospital to its nursing home. A chain may also own pharmacies or sell hospital supplies to a ready-made captive market in its hospitals and nursing homes at high non-competitive prices. Chains actively solicit and sell stock to local doctors who thereafter are inescapably subject to questions of conflict of interest any time they place patients in and order services in medical facilities in which they have an ownership interest.

Certainly, no case can or should be made solely because of size against an organization which limits its activity to a number (even a large number) of a single type of health care facility—such as skilled nursing homes. In such instances, where the chain operates beds which are needed in a community and without the presence of conflicts of interest, opportunities exist for significant economies and efficiency in the provision of necessary health care. The problems arise with respect to the over-promoted chains consisting of conglomerations of various types of health care facilities and services where, in the final analysis,

the Government, in the main, is expected to recognize for reimbursement inflated prices paid by those chains in their eagerness to expand and demonstrate growth, presumably in order to generate demand for their stock.

For example, one hospital chain sought to establish as cost bases for depreciation reimbursement under Medicare, the following:

	Hospital A	Hospital B	Hospital C
Book value-----	\$319, 572	\$277, 174	\$173, 409
Sales price-----	2, 250, 000	4, 800, 000	1, 800, 000

The Bureau of Health Insurance correctly refused to accept the cost bases claimed by the chain.

Other hospitals and skilled nursing homes are being built or proposed for communities where existing facilities are adequate to serve the needs of those areas. In most instances, this construction is not subject to approval of areawide planning agencies and if prior experience is any yardstick, if a bed is available it will be filled.

In the above instances, bona fide competition does not occur with respect to whether one facility is more efficient and economical than another. What competition does exist is for scarce health manpower and patients—both generating further upward pressure on already high costs.

Competition for Patients Can Lead to Conflict of Interest

In the competition for paying patients, several of the largest chains, deliberately follow a policy of selling stock to local physicians as a means of assuring that the new facility will get paying patients.

Unquestionably, many physicians, who have an ownership interest in a facility, are not motivated by that interest in their treatment of patients. Nonetheless, there is always the appearance of a potential or implicit conflict-of-interest in physician ownership of a health care facility or service in which he treats his patients in terms of admissions policy, the range and frequency of services supplied, and dates of patient discharge.

Abuse Revealed in Some Cases of Physician Ownership of Facilities

There is a requirement in Title 19 of the Social Security Act that States maintain a current list of owners of interests of 10 percent or more in skilled nursing homes. The staff requested those lists, and then, on a sample basis due to the massive amount of material received, cross-checked on physician-owners of nursing homes who had also received payments of \$25,000 or more from medicare in 1968. On the following several pages are reproduced the medicare payments records of some general practitioners located in small towns in the State of Texas. These physicians each have financial interests in skilled nursing homes and in some cases proprietary hospitals as well. The amounts and patterns of charges are unusual. In particular the frequency of visits to institutionalized patients and the aggregate amounts billed for such visits as well as for injections and laboratory services indicate an obvious need for thorough followup.

*Summary of Physician Reimbursement Under Medicare Calendar 1968,
Group Medical and Surgical Service, Texas*

**SECTION B—MEDICARE REIMBURSEMENT AND PATIENT
PROFILE**

Type of service	Allowed charges	Number of patients	Number of services
PHYSICIAN A:			
1. Total-----	\$84, 578. 50	351	17, 099
Less deductible and coinsur- ance-----	27, 238. 42		
Amount reimbursed-----	57, 340. 08		
2. Visits:			
(a) Office visits-----	12, 755. 00	286	2, 554
(b) Home visits-----	3, 056. 00	47	306
Nursing home visits-----	870. 00	28	77
(c) Hospital visits-----	38, 326. 00	174	7, 239
(d) ECF visits-----	0		
(e) Out-patient clinic visits-----	0		
3. Surgery:			
(a) Surgical-----	1, 299. 00	38	74
(b) Assistant surgery-----	5. 00	1	1
4. Laboratory tests-----	8, 360. 00	239	1, 841
5. Diagnostic X-ray-----	2, 050. 00	92	177
6. Therapeutic X-Ray-----	0		
7. Physiotherapy-----	281. 00	6	59
8. Injectable drugs:			
(a) Injection only-----	12, 856. 00	298	4, 198
(b) Office visit with injection-----	1, 264. 00	66	206
(c) Home visit with/injection-----	223. 00	9	20
9. Psychiatric counselling-----	0		
10. All other:			
(a) Consultations-----	0		
(b) All other-----	3, 233. 00	123	347
PHYSICIAN B:			
1. Total-----	117, 824. 50	300	14, 338
Less deductible and coinsur- ance-----	33, 978. 14		
Amount reimbursed-----	83, 846. 36		
2. Visits:			
(a) Office visits-----	8, 167. 00	208	1, 355
(b) Home visits-----	1, 620. 00	29	154
Nursing home visits-----	83, 020. 00	104	8, 332
(c) Hospital visits-----	8, 509. 00	69	1, 378
(d) EFC visits-----	0		
(e) Out-patient clinic visits-----	0		
3. Surgery:			
(a) Surgical-----	679. 00	19	21
(b) Assistant surgery-----	505. 00	9	9
4. Laboratory tests-----	10, 461. 00	208	2, 136
5. Diagnostic X-ray-----	714. 50	69	76
6. Therapeutic X-ray-----	0		
7. Physiotherapy-----	0		

*Summary of Physician Reimbursement Under Medicare Calendar 1968,
Group Medical and Surgical Service, Texas—Continued*

**SECTION B—MEDICARE REIMBURSEMENT AND PATIENT
PROFILE—Continued**

Type of service	Allowed charges	Number of patients	Number of services
8. Injectable drugs:			
(a) Injection only.....	\$3, 731. 00	158	840
(b) Office visit with injection..	188. 00	7	19
(c) Home visit with injection..	10. 00	1	1
9. Psychiatric counselling.....	0		
10. All other:			
(a) Consultations.....	15. 00	1	1
(b) All other.....	205. 00	12	16
PHYSICIAN C:			
1. Total.....	65, 769. 60	183	13, 132
Less deductible and coinsur- ance.....	19, 345. 32		
Amount reimbursed.....	46, 424. 28		
2. Visits:			
(a) Office visits.....	12, 008. 00	155	2, 539
(b) Home visits.....	11, 913. 50	104	1, 412
Nursing home visits.....	92. 00	2	10
(c) Hospital visits.....	7, 319. 00	45	1, 114
(d) ECF visits.....	0		
(e) Out-patient clinic visits.....	0		
3. Surgery:			
(a) Surgical.....	985. 00	40	100
(b) Assistant surgery.....	100. 00	2	2
4. Laboratory tests.....	6, 466. 00	129	1, 618
5. Diagnostic X-ray.....	1, 987. 00	71	146
6. Therapeutic X-ray.....	0		
7. Physiotherapy.....	15. 00	3	3
8. Injectable drugs:			
(a) Injection only.....	17, 799. 50	167	5, 372
(b) Office visit with injection..	2, 780. 00	53	362
(c) Home visit with injection..	2, 872. 00	59	272
9. Psychiatric counseling.....	0		
10. All other:			
(a) Consultations.....	7. 00	1	1
(b) All other.....	1, 425. 60	43	181
PHYSICIAN D:			
1. Total.....	74, 037. 67	276	13, 797
Less deductible and coinsur- ance.....	22, 655. 81		
Amount reimbursed.....	51, 381. 86		
2. Visits:			
(a) Office visits.....	5, 261. 50	228	1, 229
(b) Home visits.....	386. 00	12	48
Nursing home visits.....	5, 645. 00	14	706
(c) Hospital visits.....	5, 646. 00	79	997
(d) ECF visits.....	0		
(e) Out-patient clinic visits.....	0		
3. Surgery:			
(a) Surgical.....	1, 884. 50	52	96
(b) Assistant surgery.....	0		

*Summary of Physician Reimbursement Under Medicare Calendar 1968,
Group Medical and Surgical Service, Texas—Continued*

**SECTION B—MEDICARE REIMBURSEMENT AND PATIENT
PROFILE—Continued**

Type of service	Allowed charges	Number of patients	Number of services
4. Laboratory tests-----	\$7, 138. 17	212	1, 397
5. Diagnostic X-ray-----	4, 296. 00	172	348
6. Therapeutic X-ray-----	0		
7. Physiotherapy-----	1, 448. 00	38	362
8. Injectable drugs:			
(a) Injection only-----	20, 571. 00	250	5, 086
(b) Office visit with injections--	5, 454. 00	188	1, 139
(c) Home visit with injections--	12, 596. 00	43	1, 581
9. Psychiatric counselling-----	0		
10. All other:			
(a) Consultations-----	235. 00	15	17
(b) All other-----	3, 476. 50	91	791

PHYSICIAN E:

1. Total-----	64, 030. 00	328	11, 402
Less deductible and coinsurance-----	20, 528. 98		
Amount reimbursed-----	43, 501. 02		
2. Visits:			
(a) Office visits-----	7, 638. 00	261	1, 465
(b) Home visits-----	0		
Nursing home visits-----	3, 540. 00	17	708
(c) Hospital visits-----	32, 204. 00	209	5, 824
(d) ECF visits-----	0		
(e) Out-patient clinic visits--	202. 00	21	26
3. Surgery:			
(a) Surgical-----	675. 00	25	36
(b) Assistant surgery-----	170. 00	3	3
4. Laboratory tests-----	8, 437. 00	225	1, 606
5. Diagnostic X-ray-----	704. 00	116	137
6. Therapeutic X-ray-----	0		
7. Physiotherapy-----	9. 00	1	3
8. Injectable drugs:			
(a) Injection only-----	4, 193. 00	198	1, 178
(b) Office visit with injection--	956. 00	64	133
(c) Home visit with injection--	0		
9. Psychiatric counseling-----	0		
10. All other:			
(a) Consultations-----	1, 800. 00	48	60
(b) All other-----	3, 502. 00	124	223

PHYSICIAN F:

1. Total-----	94, 015. 01	224	13, 570
Less deductible and coinsurance-----	22, 794. 36		
Amount reimbursed-----	71, 220. 65		
2. Visits:			
(a) Office visits-----	7, 057. 00	157	1, 197
(b) Home visits-----	82. 00	6	24
Nursing home visits-----	2, 060. 00	5	206
(c) Hospital visits-----	14, 220. 00	74	1, 407
(d) ECF visits-----	0		
(e) Out-patient clinic visits--	0		

*Summary of Physician Reimbursement Under Medicare Calendar 1968,
Group Medical and Surgical Service, Texas—Continued*

**SECTION B—MEDICARE REIMBURSEMENT AND PATIENT
PROFILE—Continued**

Type of service	Allowed charges	Number of patients	Number of services
3. Surgery:			
(a) Surgical.....	\$970. 50	38	53
(b) Assistant surgery.....	80. 00	2	2
4. Laboratory tests.....	37, 597. 51	157	6, 575
5. Diagnostic X-ray.....	11, 016. 00	140	692
6. Therapeutic X-ray.....	5. 00	1	1
7. Physiotherapy.....	1, 260. 00	65	248
8. Injectable drugs:			
(a) Injection only.....	5, 226. 50	135	1, 038
(b) Office visit with injection..	2, 128. 50	69	329
(c) Home visit with injection..	8, 780. 00	54	1, 569
9. Psychiatric counseling.....	0	-----	-----
10. All other:			
(a) Consultations.....	2, 440. 00	68	88
(b) All other.....	1, 092. 00	42	141

In addition to efforts to have unusually high cost bases recognized for purposes of medicare reimbursement, some chains (as well as some consulting firms who own stock in institutions for which they consult) have also sought acceptance as reimbursable costs of unusually high salary, franchise fee, percentage of gross-income, and purchases from related organization arrangements. Social Security has recently stepped-up its efforts to detect and prevent abuse in those areas and that activity is certainly justified and worthwhile.

Conversion From Proprietary to "Non-Profit" Status Profitable

Another area of concern which has implications, not only for Medicare and Medicaid, but also for the tax collector involves a trend toward changing the status of a proprietary health care facility to that of a "non-profit" institution. For example, a group of physicians who own a proprietary hospital with a depreciated replacement cost of \$2 million might claim a "fair market value" of \$4 million (inclusion of good will, etc.) and sell it for that sum to a non-profit organization which they in fact control. The purchase price is to be paid from the excess of cash flow over expenses of the hospital. Prior to the transfer of ownership, the hospital may have had average net income of \$200,000 subject to ordinary tax. That \$200,000 now becomes tax-free and is applied toward payment of the inflated \$4 million purchase price (along with other items of cash flow such as depreciation) where, in large part, it becomes subject to capital gains tax rates rather than ordinary income rates.

A principal problem in these situations is that, under existing law, it is debatable whether the Internal Revenue Service can deny tax-exempt status to nonprofit hospitals or nursing homes engaging in transactions of this type, particularly where there is allegedly arm's-length dealing.

Examples of Shifts From Proprietary to "Non-Profit" Ownership

Following is a brief, general description provided by the Internal Revenue Service of transactions which illustrate what may occur to asset valuations when proprietary hospitals are sold to nonprofit organizations and where the purchasing organization pays an amount in excess of the depreciated replacement cost of the facility:

(1) Hospital *A* is an 80-bed hospital located in an urban area. It is in a building 60 years old. Many of the facilities, such as plumbing, electricity, etc., are obsolete and inadequate for modern hospital functions. It originated as a business venture involving various corporate and individual stockholders. It lacks any real emergency room and has neither outpatient nor obstetrics departments. Some remodeling work has begun on the facility. The owners of the proprietary hospital were instrumental in creating a nonprofit corporation, formed to purchase and take over control of the proprietary hospital.

The incorporators of the nonprofit organization owned over 50% of the proprietary hospital's stock. Over one-half of the board of directors consists of stockholders in the proprietary corporation. An appraisal of the fair market value of the hospital furnished to the nonprofit organization used the income approach to evaluation, i.e., capitalization of excess earnings. It placed a value of \$1,300,000 upon the hospital which was shown as the selling price. An Internal Revenue Service valuation engineer, working with the assistance of personnel of the Department of HEW, applied a cost approach to the evaluation of the hospital. His fair market value, based on depreciated replacement cost was \$243,000. His position was that the income approach is not a valid method of evaluating the worth of a nonprofit hospital. It is also noted that the entire purchase price is evidently to be repaid out of the future earnings of the hospital, thus converting ordinary income into capital gains in the hands of the sellers. This tax matter is currently pending.

(2) Hospital *B* is a 160 bed hospital. At the time of sale, the building was 18 months old. It was set up as a proprietary hospital by a hospital administrator and a group of business men for investment purposes. It has developed a large medical staff and is the only hospital in the suburban community which it serves. The nonprofit organization is alleged to have been created by three disinterested citizens concerned with the welfare of the community. The owners of the proprietary hospital obtained an appraisal of the facility in the sum of \$5,000,000 and furnished it to the nonprofit organization. The fair market value was arrived at through the use of the income approach. The market and cost approaches indicated in the appraisal reflect a lower value. Relying on the sellers' appraisal, the nonprofit organization purchased the hospital for \$5,000,000. The sales agreement provided for the continued employment of the former administrator, who was also a substantial stockholder in the proprietary corporation.

The administrator was given a good deal of control and authority over the hospital's future operations under the selling agreement as a means of safeguarding the seller's interest since the purchase price was apparently to be paid out of the future earnings of the hospital. Two of the original shareholders were added to the Board of Directors after the sale was consummated. The IRS valuation engineer rejected the income approach taken in the seller's appraisal as invalid for the

sale of a nonprofit hospital and applied a cost approach. With the assistance of HEW experts, he arrived at a depreciated replacement cost of \$2,900,000 as the fair market value of the hospital. The application for exemption under section 501(c)(3) of the Internal Revenue Code was denied by the District Director. The nonprofit organization brought suit in the Court of Claims and the matter is now pending in litigation.

(3) Hospital *C* is a 250 bed hospital. The building is 11 years old, but contains a new wing with 150 beds. The proprietary hospital was formed by a number of physicians interested in having a hospital in which to practice. The hospital is located in a large urban area. A nonprofit organization was created. Three out of seven members of the Board of Trustees were former stockholders of the proprietary hospital. The officers and administrator of the proprietary hospital were retained by the nonprofit organization. An appraisal was obtained. The appraisal used the income approach and placed the fair market value at slightly over \$5,000,000. The hospital was sold for \$5,000,000. The IRS valuation engineer in this case accepted the income approach as a valid means of establishing fair market value.

The value of the tangible assets was placed at \$2,310,000 and the intangible assets or going concern value of the hospital was fixed at \$2,789,000. The purchasing, nonprofit organization had plans to begin a number of new educational and training projects. The organization was held exempt under section 501(c)(3) of the Internal Revenue Code by the national office of IRS.

(4) Hospital *D* is a 120 bed clinic. Most of the facilities were over 50 years old at the time of the transaction, but the hospital had recently expanded from 60 to 120 beds. Its principal purpose was the treatment of mental illness. It was begun by a private practitioner and expanded its medical staff to include a number of additional owner-doctors. The nonprofit organization was created by the same physicians who owned the clinic. The director of the proprietary clinic continued in charge of the nonprofit clinic. They obtained an appraisal which based fair market value on the income approach. The appraisal indicated the value of the tangible assets to be \$1,122,000 and the goodwill to be \$656,000. The clinic was sold for \$1,700,000. The IRS appraisal, using the income approach, agreed with the value placed on the tangible assets, but valued the goodwill at \$200,000. For this reason, nonprofit tax exemption was denied by the national office of the IRS.

Recommendation

It is suggested that the committee consider requesting the Department of the Treasury to submit such legislative proposals or other recommendations as may be deemed necessary to avoid abuse of tax-exempt status and capital gains treatment in the sale or exchange of health care facilities. Particularly, the Treasury should suggest means of valuing such facilities which do not possess the manipulative potential suggested by the examples submitted by the Internal Revenue Service.

With respect to asset valuations for purposes of reimbursement under medicare and medicaid, the staff has recommended earlier in this report that "goodwill" not be recognized as an element of cost where a transfer of ownership occurs. Further, depreciation expense should be recognized only on the same basis as in the tax laws—straight-line historical cost.

CHAPTER SEVENTEEN

REPORTING OF MEDICAL PAYMENTS TO TAX COLLECTOR

Until very recently, insurance companies (including those participating in medicare), many Blue Cross-Blue Shield organizations, State agencies participating in the medicaid program, and employers and unions having self-insured or self-administered health plans did not file information returns with the Internal Revenue Service when they made payments to (or with respect to) doctors, dentists, and other suppliers of medical and health care services and goods on behalf of individuals.

On November 13, 1969, largely in response to views expressed during hearings before the Committee on Finance (hearings on medicare and medicaid, July 1 and 2, 1969), the Internal Revenue Service revoked its prior policy and announced that henceforth information returns would be required with respect to payments aggregating \$600 or more made to a doctor or other provider. Payments made to corporations (including professional service corporations set up by doctors for tax purposes) were specifically excepted from this reporting requirement.

No doubt this change in attitude by the Internal Revenue Service and the publication of its new position requiring information returns with respect to medical payments made to doctors and other providers prompted the conferees on the Tax Reform Act to omit a Senate amendment added to the bill by the Committee on Finance before the Service position was reversed. This Senate amendment called for detailed reporting of medical payments, including payments made to an insured person, either in reimbursement for payments he had made to a doctor or other provider, or with respect to services performed by the doctor or other provider.

The staff believes the present requirements of the Internal Revenue Service leave much to be desired. As already noted, they do not cover payments made to corporations. Nor do they cover the so-called indirect payments—those payments made to the insured who receives the amount, either as reimbursement for payment he has already made, or who presumably will use the proceeds in settlement of an unpaid bill. The staff views this shortcoming of the present reporting requirement as a substantial defect which can lead to massive shifts in billing practices by doctors and other providers of health care services seeking to avoid having their payments reported to the tax collector. Such a shift could also have a serious implications with respect to the patient who may be unable to pay his doctor first and then seek reimbursement under his health insurance policy.

Another important defect in the new reporting requirements concerns the inability of the Internal Revenue Service to require the payer

to furnish the doctor or other provider of medical services, goods, or supplies with a copy of the information return or similar statement. We believe it is important that the doctor or other provider be informed of the amount reported to the Internal Revenue Service as having been paid with respect to services he rendered or goods and supplies he furnished.

Yet another defect in the new reporting requirements is their failure to impose a reporting responsibility upon payees acting as conduits and who, in fact, merely transfer the insurance proceeds to the taxpayer actually rendering the services. For example, many clinics or associations of doctors may designate a single doctor to receive payment for services rendered by all the doctors in the clinic or association. The same could be true of doctors who join together in a professional service corporation for the practice of medicine. The staff believes the information required under the new Internal Revenue Service requirement will not be very useful as an enforcement device because IRS cannot know which doctor received what portion of a consolidated group payment.

Unfortunately, these defects largely reflect shortcomings in the statute itself, and few, if any of them, can be corrected by further administrative action.

Probably the most serious shortcoming of the present reporting requirement, however, concerns whether it is supported by the present law. The applicable statute (sec. 6041 of the Internal Revenue Code) requires "all persons engaged in a trade or business and making payments in the course of such trade or business" to render a true and accurate return reporting payments to another person aggregating \$600 or more during the year. It has been argued that payments paid by an insurance company to or on behalf of a private citizen for health care goods and services are not encompassed by this language. Rather it is argued that the insurance company, in such cases, merely acts as the agent of the private citizen. And, pursuing the analogy, since the private citizen is not required to report payments he makes to his doctor for services rendered to him, neither is the insurance company.

The Internal Revenue Service position with respect to this question is stated as follows in the Revenue ruling announcing the new reporting requirement:

Payments of fees under the plans, programs, or policies here considered to doctors or other suppliers of health care services are made in the course of the trade or business of the persons making the payment. Accordingly, it is held that such persons are required to file forms 1099 with respect to such payments made directly to doctors or other suppliers. (Rev. Rul. 69-595—Nov. 13, 1969.)

The staff has already observed that the new reporting requirement fails to require reports of indirect payments (those made to a private person for a bill paid or to be repaid, to a doctor or other provider). At this point we express the fear that the controversy described in the two immediately preceding paragraphs could develop into litigation which might place the validity of the present reporting requirement in doubt for years to come.

With a payer of dividends and interest now required to report payments to a person aggregating \$10 or more during the year (with additional statements required of nominees identifying the principal to whom they repaid the amounts) the present reporting requirements with respect to medical payments seem particularly inadequate.

In the opinion of the staff, the committee should consider again the sort of comprehensive amendment it added to the Tax Reform Act. That amendment corrects and overcomes the defects in the new administrative reporting requirement and would provide the Internal Revenue Service with information vastly more useful to it in enforcing the tax laws of the Nation.

The features of that amendment are explained in the Report of the Committee on Finance accompanying H.R. 13270, the Tax Reform Act of 1969, in the following terms:

“4. Reporting of Medical Payments (sec. 944 of the bill, sec. 6050A of the code, and sec. 1122 of title XI of the Social Security Act)

Present law.—Under present law every person making payments in the course of his trade or business to another person of rent, salaries, and a variety of other fixed or determinable gains, profits, and income amounting to \$600 or more in a calendar year must file an information return showing the amounts paid and the name and address and identification number of the recipient.

Under Internal Revenue Service procedures in effect when the bill was ordered reported, information returns were not required of insurance companies (including those participating in medicare), Blue Cross-Blue Shield organizations, State agencies participating in the medicaid program, and employers and unions having self-insured or self-administered plans, when they made payments to doctors, dentists, and other suppliers of medical and health care services and goods on behalf of individuals. These organizations are now required by the Internal Revenue Service to make information returns with respect to payments to doctors and other suppliers.

General reasons for change.—Although these organizations are now required by the Internal Revenue Service to make information returns with respect to direct payments to doctors and other suppliers, there is no authority under existing law to require reporting by these organizations of payments made to the patients for services or goods furnished by the suppliers even though in normal circumstances they are paid over to the suppliers or represent reimbursements of earlier payments made by the patients.

The committee believes it desirable to provide specific rules requiring information returns to be filed with respect to payments in excess of \$600 during the calendar year to suppliers of medical goods and services, whether the payments are made directly to the supplier or to the patient or other third party in reimbursement for payments to the supplier. To omit reporting of payments where they are not made directly to the supplier could encourage the use of indirect payments in order to avoid reporting for Federal income tax purposes.

Explanation of provision.—The committee has added to the bill a provision requiring the filing of an information return for payments of \$600 or more made during the calendar year to a supplier of medical goods and services. The reporting requirement covers payments to doctors, dentists, and other suppliers of medical and health care services. It also covers payments for medical and health care goods and services such as medicines and orthopedic and prosthetic devices, and medicine and other goods and services rendered, furnished or dispensed by doctors, dentists, and other suppliers of medical services.

The requirement also applies to payments made to any person in reimbursement for amounts paid or payable to a supplier. For example, an insurance company must report as payment to a doctor an amount paid by it to a patient in reimbursement of amounts paid or payable to the doctor by the patient.

All payments, whether made directly to the supplier or to another person in reimbursement for amounts paid or payable to the supplier, must be aggregated in determining the amount paid during the year.

The following exceptions from these requirements are provided:

(1) The reporting requirement does not apply to payments not made in the course of a trade or business. For example, the requirement applies to an insurance company that pays an insured patient's doctor bill for medical services or reimburses the insured patient for the amount of the doctor bill, but it does not apply to the patient himself when he pays a doctor, because he is not making the payment in the course of a trade or business.

(2) The provision does not apply to the payment of wages subject to withholding by an employer (with respect to which a statement is made under section 6051), a payment to a tax-exempt organization described in section 501(c)(3), or a payment to an agency or instrumentality of the United States or a State or political subdivision of a State.

(3) The provision does not apply to payments for goods or services dispensed or supplied by a noninstitutional pharmacy.

(4) The reporting required does not apply to any payment to an individual by his attorney or agent, or to any payment made by a person with respect to which a return is made by any other person.

(5) In the case of a payment in settlement of a claim which includes reimbursement for amounts paid or payable to a supplier of medical and health care services or goods, reporting is required only to the extent that these amounts have been separately identified to the person making the payment. (The payment must contain determinable sums specifically attributable to identified persons.) For example, if a casualty insurer makes a lump sum settlement which encompasses not only medical expenses but also compensation for personal injuries or property damage, the medical expenses must be reported only to the extent they have been separately identified to the insurance company.

(6) In many cases, the amount of expenses for medical and health care goods and services is greater than the amount reimbursed by the insurance company. This may be the case, for

example, where the insurance company reimburses only a specified percentage of medical expenses, or where no reimbursement is made for a fixed initial amount, such as \$100. The bill gives the Secretary of the Treasury or his delegate regulatory authority to provide for the determination of the amount paid to each supplier in these cases where the reimbursement covers more than one supplier, and the payment does not separately state the amount paid in reimbursement of amounts paid or payable to each supplier.

The committee recognizes that the provisions requiring reporting of payments to persons in reimbursement for amounts paid or payable to suppliers will impose an additional burden on insurance companies and other organizations from whom reporting is required. However, the committee believes it is necessary to require reporting of these payments to prevent a shift to indirect payment of doctors and other suppliers which would undermine the effectiveness of the requirement that direct payments be reported. The committee expects that the Commissioner of Internal Revenue will work with the insurance industry and with other reporting organizations to devise methods of reducing the cost of complying with the new reporting requirements.

The committee also recognizes that amounts reported as payments to suppliers which are actually payments to other persons in reimbursement for amounts billed by suppliers will not always accurately reflect the actual income of the supplier. The committee anticipates that the amounts reported under this provision will be helpful to the Internal Revenue Service in selecting returns for audit and in providing background information with respect to the audit of returns of suppliers, but it does not intend that the reports be used as evidence in themselves of income received by the supplier.

The bill provides that the information supplied in the information return with respect to any person is to be furnished to that person on or before January 31 of the following calendar year. For example, if a separate form is supplied to the Internal Revenue Service with respect to each payee, a copy of the form is to be sent to the payee." (S. Rept. 91-552, 91st Cong., first sess., 1969, pp. 298-301.)

The staff observes that failure to adequately report the billions of dollars in health care payments constitutes a major gap—if not the major gap—in the IRS's information gathering process. These health insurance payments, if fully and properly reported, will provide the Internal Revenue Service with a more detailed and complete picture of the gross income of hundreds of thousands of taxpayers.

The concern with seeing that these billions are routinely reported to IRS does not imply any wrongdoing or tax evasion on the part of those receiving private health insurance payments. It simply reflects a legitimate concern that our income-reporting system be as inclusive and comprehensive as possible. Certainly, every honest taxpayer shares in that concern.

APPENDIX A

Additional Tabular Analysis of Payments to Physicians Receiving \$25,000 or More in 1968

APPENDIX A.—ADDITIONAL TABULAR ANALYSIS OF PAYMENTS TO PHYSICIANS RECEIVING \$25,000 OR MORE IN 1968

Table 1.—Physicians reimbursed \$25,000 or more under Medicare during calendar year 1968: Number of physicians distributed by number of beneficiaries treated and by amount reimbursed

[Excludes physicians known to be in group practice]

Number of beneficiaries treated	All physicians	Number of physicians by amount reimbursed (in thousands)											150 and over
		25-29.9	30-34.9	35-39.9	40-44.9	45-49.9	50-74.9	75-99.9	100-124.9	125-149.9			
Number of physicians	4, 284	1, 595	960	552	340	226	432	111	40	10	18		
Under 50	8	5		3									
50 to 74	43	29	6	3	3	1	1						
75 to 99	121	81	23	5	3	2	7						
100 to 124	256	149	58	23	15	4	7						
125 to 149	355	193	72	35	20	10	23	2					
150 to 174	411	198	105	52	23	15	14	4					
175 to 199	431	204	120	48	27	13	14	5					
200 to 224	421	168	117	62	26	17	27	3	1				
225 to 249	408	152	112	53	30	20	34	6	1				
250 to 274	281	94	67	48	23	15	29	3	2				
275 to 299	281	81	61	53	31	17	34	3	1				
300 to 324	217	65	43	26	25	19	31	6	2				
325 to 349	155	34	39	24	14	18	16	9					
350 to 374	123	27	27	15	12	12	23	2	4			1	
375 to 399	96	18	19	15	15	7	20	1	1			1	
400 to 424	88	13	16	11	11	5	25	5	1			1	
425 to 449	70	10	7	13	6	2	21	7	3	1		2	
450 to 474	51	7	1	9	4	7	14	5		2		2	
475 to 499	56	5	2	8	6	6	18	10		1			
500 to 549	58	8	7	9	7	7	9	6	5				
550 to 599	48	7	2	3	8	5	15	3	4			1	
600 to 649	21	4	2	5	1	1	3	5				1	

**APPENDIX A.—ADDITIONAL TABULAR ANALYSIS OF PAYMENTS TO PHYSICIANS RECEIVING \$25,000
OR MORE IN 1968—Continued**

TABLE 1.—*Physicians reimbursed \$25,000 or more under Medicare during calendar year 1968: Number of physicians distributed by number of beneficiaries treated and by amount reimbursed—Continued*

Number of beneficiaries treated	All physicians	Number of physicians by amount reimbursed (in thousands)											150 and over
		25-29.9	30-34.9	35-39.9	40-44.9	45-49.9	50-74.9	75-99.9	100-124.9	125-149.9			
650 to 699	25	2	6	2	2	2	4	3	2	—	—	—	2
700 to 749	23	1	1	2	3	4	6	4	2	—	—	—	—
750 to 799	20	1	4	2	3	—	7	1	2	—	—	—	—
800 to 849	18	6	—	2	1	2	3	1	3	—	—	—	—
850 to 899	8	2	—	—	1	—	2	—	—	1	—	—	—
900 to 949	17	6	2	2	1	1	1	1	1	—	—	—	1
950 to 999	14	7	3	2	2	—	—	2	—	—	—	—	—
1,000 to 1,199	50	16	13	7	4	3	3	1	1	1	—	—	1
1,200 to 1,399	28	2	11	3	4	1	2	1	1	—	—	—	3
1,400 to 1,599	21	—	7	4	4	2	2	1	—	—	—	—	1
1,600 to 1,799	21	—	5	4	2	4	2	1	1	1	—	—	1
1,800 to 1,999	8	—	—	—	2	3	2	—	—	1	—	—	—
2,000 and over	32	—	—	—	1	1	13	10	2	2	—	—	3

TABLE 1A.—*Number of group practices reimbursed \$25,000 or more under Medicare during calendar year 1968 distributed by number of beneficiaries treated and amount reimbursed*

Number of beneficiaries treated	Number of physicians by amount reimbursed (in thousands)												200 and over
	All groups	25-29.9	30-34.9	35-39.9	40-44.9	45-49.9	50-74.9	75-99.9	100-124.9	125-149.9	150-199.9		
Number of groups ¹													
Under 200	905	203	145	91	56	58	152	69	27	23	25	56	
200 to 249	89	45	26	10	3	1	4	1					
250 to 299	54	31	11	4	2	1	4	1					
300 to 349	87	32	23	13	5	6	7	1					
350 to 399	62	21	17	8	1	4	6	4	1				
400 to 449	73	10	14	18	10	7	10	3			1		
450 to 499	52	8	12	5	8	9	9	1					
500 to 599	44	5	10	3	3	9	12	2					
600 to 699	66	8	6	4	10	5	20	10	1		2		
700 to 799	46	4	3	7	3		20	6	1	2			
800 to 899	42	6	3	4	1		14	6	6		1		
900 to 999	32	5	1	1		2	8	12	1	2		1	
1,000 to 1,199	36	6	5	2		1	4	5	6	4	3		
1,200 to 1,399	54	14	6	2		4	8	4	3	6	2	5	
1,400 to 1,599	42	5	6	3	2	2	7	1	1	3	6	6	
1,600 to 1,799	32	2	1	3	2	3	2	2	1	2	7	7	
1,800 to 1,999	22		1		5	2	3			1	1	9	
2,000 and over	11			1		1	4		1	1		3	
	61	1		3	1	1	10	11	5	2	2	25	

¹ Represents number of clinics and group practices so identified in social security records. Number of individual physicians represented is not known.

TABLE 2.—Physicians reimbursed \$25,000 or more under Medicare during calendar year 1968, etc.—Continued

	Ophthalmology			Radiology			Urology			Other specialties			Groups ³	
	Number	Percent		Number	Percent		Number	Percent		Number	Percent		Number	Percent
Number of physicians..	425	100.0		223	100.0		782	100.0		181	100.0		905	100.0
Under \$20	—	0	2.2	5	2.2	—	—	0	—	2	1.1	—	10	1.1
\$20.00 to \$29.99	—	0	36.3	81	36.3	—	—	0	—	16	8.8	—	65	7.2
\$30.00 to \$39.99	—	0	19.3	43	19.3	—	—	0	—	2	1.1	—	45	5.0
\$40.00 to \$49.99	1	.2	11.2	25	11.2	—	—	0	—	9	5.0	—	29	3.2
\$50.00 to \$59.99	8	1.9	4.5	10	4.5	—	—	.1	—	11	6.1	—	38	4.2
\$60.00 to \$69.99	4	.9	2.2	5	2.2	—	1	.1	—	7	3.9	—	47	5.2
\$70.00 to \$79.99	—	—	2.4	—	—	—	5	.6	—	12	6.6	—	42	4.6
\$80.00 to \$89.99	18	4.2	3.6	8	3.6	—	13	1.7	—	6	3.3	—	56	6.2
\$90.00 to \$99.99	19	4.5	1.3	3	1.3	—	21	2.7	—	11	6.1	—	85	9.4
\$100.00 to \$124.99	72	16.9	3.1	7	3.1	—	92	11.8	—	16	8.8	—	179	19.8
\$125.00 to \$149.99	81	19.1	2.2	5	2.2	—	194	24.8	—	13	7.2	—	115	12.7
\$150.00 to \$174.99	52	12.2	2.2	5	2.2	—	165	21.1	—	17	9.4	—	76	8.4
\$175.00 to \$199.99	49	11.5	.9	2	.9	—	106	13.6	—	7	3.9	—	36	4.0
\$200.00 to \$224.99	42	9.9	1.3	3	1.3	—	75	9.6	—	9	5.0	—	32	3.5
\$225.00 to \$249.99	22	5.2	.9	2	.9	—	39	5.0	—	13	7.2	—	16	1.8
\$250.00 to \$274.99	11	2.6	1.3	3	1.3	—	32	4.1	—	5	2.8	—	9	.9
\$275.00 to \$299.99	12	2.8	.4	1	.4	—	20	2.6	—	2	1.1	—	8	.7
\$300.00 to \$324.99	5	1.2	.9	2	.9	—	2	.3	—	6	3.3	—	6	.7
\$325.00 to \$349.99	—	—	—	—	—	—	2	.3	—	4	2.2	—	2	.2
\$350.00 to \$374.99	6	1.4	0	—	0	—	6	.8	—	—	0	—	4	.4
\$375.00 to \$399.99	2	.5	0	—	0	—	2	.3	—	—	.6	—	1	.1
\$400.00 to \$449.99	—	—	0	1	.4	—	4	.5	—	1	1.1	—	4	.4
\$450.00 to \$499.99	—	0	0	—	0	—	—	0	—	2	1.1	—	—	0
\$500.00 to \$599.99	1	.2	0	—	0	—	1	.1	—	3	1.7	—	—	0
\$600.00 to \$699.99	—	0	.4	1	.4	—	—	0	—	2	1.1	—	—	0
\$700.00 to \$799.99	—	0	0	—	0	—	1	.1	—	—	0	—	—	0
\$800.00 and over	—	0	0	—	0	—	—	0	—	1	.6	—	—	0
Median payment amount	\$149.7		\$40.7		\$159.7		\$121.9		\$105.0				\$105.0	
Mean payment amount	\$141.41		\$38.19		\$160.80		\$141.57		\$93.75				\$93.75	

¹ Includes neurological, oral, orthopedic, plastic, and thoracic surgery.² Includes subspecialties such as gastroenterology, cardiovascular disease, etc.³ Represents number of clinics and group practices so identified in social security records. Number of individual physicians represented is not known.

TABLE 3.—Physicians reimbursed \$25,000 or more under medicare during calendar year 1968. Number and percent of physicians and of physician groups by proportion of beneficiaries treated surgically and by physician specialty for selected specialties

Surgical treatment ratio ¹	General practice		General surgery		Other surgery ²		Internal medicine ³		Ophthalmology		Urology		Other specialties		Groups ⁴	
	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent
Number of physicians-----	625	100.0	590	100.0	274	100.0	1,184	100.0	425	100.0	782	100.0	404	100.0	905	100.0
0-----	52	8.3	2	.3	---	---	183	15.5	---	---	---	---	76	18.8	81	9.0
Less than 5-----	281	45.0	17	2.9	3	1.1	800	67.6	1	.2	8	1.0	240	59.4	267	29.5
5 to 9.9-----	152	24.3	29	4.9	6	2.2	119	10.1	3	.7	14	1.8	20	5.0	94	10.4
10 to 14.9-----	47	7.5	41	7.0	10	3.7	28	2.4	8	1.9	10	1.3	14	3.5	77	8.5
15 to 19.9-----	43	6.9	40	6.8	12	4.4	21	1.8	29	6.8	16	2.1	6	1.5	81	9.0
20 to 24.9-----	16	2.6	26	4.4	14	5.1	7	.6	37	8.7	15	1.9	7	1.7	79	8.7
25 to 29.9-----	12	1.9	26	4.4	11	4.0	3	.3	29	6.8	15	1.3	5	1.2	61	6.7
30 to 34.9-----	5	.8	17	2.9	17	6.2	3	.3	46	10.8	23	2.9	2	.5	37	4.1
35 to 39.9-----	5	.8	20	3.4	15	5.5	2	.2	38	8.9	36	4.6	2	.5	15	1.7
40 to 44.9-----	1	.2	23	3.9	23	8.4	3	.3	41	9.7	54	6.9	4	1.0	18	2.0
45 to 49.9-----	3	.5	31	5.3	20	7.3	1	.1	41	9.7	44	5.6	1	.3	13	1.4
50 to 54.9-----	---	---	33	5.6	19	6.9	1	.1	43	10.1	65	8.3	3	.7	5	.6
55 to 59.9-----	1	.2	39	6.6	19	6.9	3	.3	30	7.1	77	9.9	5	1.2	15	1.7
60 to 64.9-----	2	.3	50	8.5	21	7.7	2	.2	28	6.6	95	12.2	5	1.2	17	1.9
65 to 69.9-----	---	---	52	8.8	27	9.9	1	.1	22	5.2	105	13.4	4	1.0	11	1.2
70 to 74.9-----	3	.5	48	8.1	19	6.9	2	.2	12	2.8	75	9.6	3	.7	10	1.1
75 to 79.9-----	---	---	41	7.0	16	5.8	1	.1	7	1.7	54	6.9	2	.5	11	1.2
80 to 84.9-----	1	.2	31	5.3	11	4.0	2	.2	6	1.4	47	6.0	3	.7	6	.7
85 to 89.9-----	---	---	15	2.5	6	2.2	2	.2	3	.7	24	3.1	1	.3	4	.4
90 to 94.9-----	---	---	5	.9	3	1.1	---	---	1	.2	9	1.2	1	.3	2	.2
95 to 99.9-----	1	.2	3	.5	2	.7	---	---	---	---	1	.1	---	---	1	.1
100-----	---	---	1	.2	---	0	---	0	---	0	---	0	---	0	---	0
Mean ratio-----	7.8		45.3		45.6		3.2		38.3		56.5		3.0		12.0	
Median ratio-----	4.6		53.5		51.6		2.6		42.6		61.0		2.6		10.6	

¹ Represents number of beneficiaries treated by an individual physician or physician group for whom medicare received one or more bills for surgical treatment expressed as a proportion of all beneficiaries treated by that physician or group.

² Includes neurological, oral, orthopedic, plastic, and thoracic surgery.

³ Includes subspecialties such as gastroenterology, cardiovascular disease, etc.

⁴ Represents number of clinics and group practices so identified in social security records. Number of individual physicians represented is not known.

TABLE 4.—Physicians reimbursed \$25,000 or more under medicare during calendar year 1968. Number and percent of physicians and physician groups distributed by proportion of beneficiaries treated in extended care facilities, and by physician specialty for selected specialties¹

ECF patient ratio ²	General practice		General surgery		Other surgery ³		Internal medicine ⁴		Ophthalmology		Urology		Other specialties		Groups ⁵	
	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent	Num-ber	Percent
Number of physicians-----	625	100.0	590	100.0	274	100.0	1,184	100.0	425	100.0	782	100.0	404	100.0	905	100.0
0-----	340	54.4	471	79.8	230	83.9	633	53.5	377	88.7	659	84.3	342	84.7	643	71.1
Less than 5-----	178	28.5	92	15.6	36	13.1	432	36.5	46	10.8	106	13.6	38	9.4	202	22.3
5 to 9.9-----	28	4.5	17	2.9	6	2.2	46	3.9	1	.2	15	1.9	11	2.7	31	3.4
10 to 14.9-----	20	3.2	5	.9	1	.4	16	1.4	1	.2	1	.1	4	1.0	13	1.4
15 to 19.9-----	12	1.9	3	.5	---	0	11	.9	---	0	1	.1	1	.3	4	.4
20 to 24.9-----	12	1.9	2	.3	1	.4	5	.4	---	0	---	0	---	0	3	.3
25 to 29.9-----	1	.2	---	0	---	0	8	.7	---	0	---	0	2	.5	1	.1
30 to 34.9-----	6	1.0	---	0	---	0	4	.3	---	0	---	0	1	.3	---	0
35 to 39.9-----	3	.5	---	0	---	0	9	.8	---	0	---	0	---	0	---	0
40 to 44.9-----	4	.6	---	0	---	0	6	.5	---	0	---	0	1	.3	1	.1
45 to 49.9-----	3	.5	---	0	---	0	1	.1	---	0	---	0	---	0	---	0
50 to 54.9-----	3	.5	---	0	---	0	3	.3	---	0	---	0	1	.3	1	.1
55 to 59.9-----	4	.6	---	0	---	0	3	.3	---	0	---	0	---	0	---	0
60 to 64.9-----	1	.2	---	0	---	0	1	.1	---	0	---	0	---	0	---	0
65 to 69.9-----	2	.3	---	0	---	0	2	.2	---	0	---	0	---	0	1	.1
70 to 74.9-----	1	.2	---	0	---	0	2	.2	---	0	---	0	---	0	---	0
75 to 79.9-----	1	.2	---	0	---	0	---	0	---	0	---	0	---	0	---	0
80 to 84.9-----	1	.2	---	0	---	0	---	0	---	0	---	0	---	0	---	0
85 to 89.9-----	2	.3	---	0	---	0	2	.2	---	0	---	0	2	.5	2	.2
90 to 94.9-----	1	.2	---	0	---	0	---	0	---	0	---	0	---	0	---	0
95 to 99.9-----	2	.3	---	0	---	0	---	0	---	0	---	0	---	0	---	0
100-----	---	0	---	0	---	0	---	0	---	0	---	0	1	.3	1	.1
Median Ratio-----	0		0		0	.7	0	3.0	0	.3	0		0		0	
Mean Ratio-----	5.8		.8		.7		3.0		.3		.3		1.3		1.5	

¹ Limited to beneficiaries receiving medical care. Excludes beneficiaries receiving only other types of service such as surgery, consultation, diagnostic X-ray, diagnostic laboratory, radiation therapy, anesthesia, and assistance at surgery during the year.

² Beneficiaries treated in ECF's as proportion of all beneficiaries receiving medical care (office visits, home visits, ECF visits, and nonsurgical hospital visits).

³ Includes neurological, oral, orthopedic, plastic, and thoracic surgery.

⁴ Includes subspecialties such as gastroenterology, cardiovascular disease, etc.

⁵ Represents number of clinics and group practices so identified in social security records. Number of individual physicians represented is not known.

TABLE 5.—Physicians reimbursed \$25,000 or more under medicare during calendar year 1968. Number and percent of physicians and physician groups distributed by proportion of beneficiaries with in-hospital medical care of all beneficiaries treated, and by physician specialty, for selected specialties¹

Inpatient Hospital ratio ²	General practice		General surgery		Other surgery ³		Internal medicine ⁴		Ophthalmology		Urology		Other specialties		Groups ⁵	
	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent	Num- ber	Per- cent
Number of physicians-----	625	100.0	590	100.0	274	100.0	1,184	100.0	425	100.0	782	100.0	404	100.0	905	100.0
0-----	28	4.5	7	1.2	1	.4	7	.6	84	19.8	5	.6	83	20.5	73	8.1
Less than 5-----	38	6.1	11	1.9	3	1.1	10	.8	274	64.5	57	7.3	32	7.9	46	5.1
5 to 9.9-----	53	8.5	23	3.9	17	6.2	29	2.5	38	8.9	107	13.7	22	5.5	65	7.2
10 to 14.9-----	49	7.8	40	6.8	17	6.2	55	4.7	14	3.3	145	18.5	28	6.9	65	7.2
15 to 19.9-----	61	9.8	42	7.1	26	9.5	91	7.7	4	.9	110	14.1	10	2.5	68	7.5
20 to 24.9-----	77	12.3	40	6.8	26	9.5	104	8.8	3	.7	80	10.2	13	3.2	57	6.3
25 to 29.9-----	69	11.0	56	9.5	26	9.5	132	11.2	1	.2	68	8.7	25	6.2	73	8.1
30 to 34.9-----	65	10.4	54	9.2	26	9.5	126	10.6	4	.9	53	6.8	22	5.5	73	8.1
35 to 39.9-----	50	8.0	54	9.2	17	6.2	121	10.2	---	---	46	5.9	14	3.5	65	7.2
40 to 44.9-----	47	7.5	56	9.5	18	6.6	108	9.1	---	---	34	4.4	17	4.2	58	6.4
45 to 49.9-----	26	4.2	32	5.4	23	8.4	92	7.8	1	.2	25	3.6	7	1.7	48	5.3
50 to 54.9-----	15	2.4	50	8.5	28	10.2	75	6.3	---	---	18	1.9	15	3.7	51	5.6
55 to 59.9-----	15	2.4	35	5.9	10	3.7	55	4.7	---	---	8	1.0	15	3.7	28	3.1
60 to 64.9-----	11	1.8	28	4.8	8	2.9	41	3.5	---	---	9	1.2	17	4.2	16	1.8
65 to 69.9-----	7	1.1	17	2.9	9	3.3	33	2.8	---	---	6	.8	18	4.5	22	2.4
70 to 74.9-----	6	1.0	18	3.1	3	1.1	36	3.0	---	.2	4	.5	4	1.0	10	1.1
75 to 79.9-----	1	.2	8	1.4	3	1.1	21	1.8	---	0	4	.5	11	2.7	13	1.4
80 to 84.9-----	3	.5	3	.5	7	2.6	17	1.4	---	.2	1	.1	12	3.0	14	1.6
85 to 89.9-----	1	.2	5	.9	1	.4	13	1.1	---	0	1	.1	6	1.5	7	.8
90 to 94.9-----	---	---	2	.3	---	0	11	.9	---	0	1	.1	1	.3	9	1.0
95 to 99.9-----	1	.2	2	.3	---	0	5	.4	---	0	---	---	1	.3	12	1.3
100-----	2	.3	7	1.2	5	1.8	2	.2	---	0	---	0	19	4.7	32	3.5
Median ratio-----	25.4		37.0		34.0		36.6		2.3		18.5		27.8		30.3	
Mean ratio-----	28.3		36.7		32.2		38.9		2.7		20.2		28.5		31.3	

¹ Limited to beneficiaries receiving medical care. Excludes beneficiaries receiving only other types of service such as surgery, consultation, diagnostic X-ray, diagnostic laboratory, radiation therapy, anesthesia, and assistance at surgery during the year.

² Beneficiaries receiving nonsurgical in-hospital care as proportion of all beneficiaries receiving medical care (office visits, home visits, ECG visits, and nonsurgical hospital visits).

³ Includes neurosurgical, oral, orthopedic, plastic, and thoracic surgery.

⁴ Includes subspecialties such as gastroenterology, cardiovascular disease, etc.

⁵ Represents number of clinics and group practices so identified in Social Security records. Number of individual physicians represented is not known.

TABULATION OF DATA ON CUMULATIVE AMOUNT OF REIMBURSEMENT TO
INDIVIDUAL PHYSICIANS BY MEDICARE¹

A. Sources of data

Data compiled by Medicare's central office on total money amounts paid to individual physicians under medicare or to beneficiaries for services provided by him must be tabulated from the payment records that carriers submit to the Administration for each payment they make under the SMI program. Payment records contain the identification number assigned to individual physicians by carriers, the amount of reimbursement, the physician's specialty, and some limited information about the type and place of service. By linking records with the same identification number, it is possible to determine the amount paid under the program by a *particular* carrier to an individual physician or to a beneficiary for services provided by that physician. The name and address of the physician are *not* reported in payment records. The payment record is the only Social Security Administration record from which this information is available. Data are also generally available, of course, from other records maintained by carriers.

B. Limitations of data

As indicated above, data on cumulative amounts paid to individual physicians are based on the identification numbers shown by carriers in payment records. Identification numbers are assigned by each carrier only to the physicians in its own service area. Since carriers may use the numbering system applicable in their own business, no uniform number system results. Carriers may change their entire numbering system over time, or may retain the system but change the number assigned to specific physicians. SSA was not always aware of such changes since carriers were not asked to report them to the Administration prior to February 1968. It is not certain that reports of number changes received are entirely complete.

To the extent that such changes occur and are not known, data derived from the payment records on total amounts paid to a particular physician during a specific time period may be assigned to two or more numbers. The effect of this problem is to understate the number of physicians receiving large total payments. Similar understatement results from the geographic limitation of carrier service areas, especially where a particular carrier serves only part of a State. For example, a physician with offices in areas served by two carriers will have two identification numbers—one assigned by each carrier. At present, there is no way for SSA to identify such situations and correlate data from the payment records submitted by each of the two carriers involved. This phenomenon occurs nationwide because of the fact that all claims involving railroad beneficiaries are handled by a separate carrier.

In some instances, a specific identification number may represent more than one physician. This situation arises for physicians who are staff members of free-standing clinics or engage in other forms of private group practice. Procedures permit all billing for services provided to medicare beneficiaries by physicians in group practice to be rendered in the name of the group itself or in the name of a single physician. In that case, only a single identification number is assigned to the group by the carrier. The medicare central office payment records do not permit identification of such groups; nor do they contain any information about the number and specialty of physicians in specific groups or the amounts paid to individual physicians. Such information, if collected, must be obtained from the carriers.

Similar problems occur in connection with the data for hospital-based physicians. Data compiled from payment records reflect payments to individual hospital-based physicians only where such physicians bill medicare beneficiaries directly. Many hospital-based physicians do not bill beneficiaries directly for their services. Instead, bills may be submitted on their behalf by the hospital(s) for which they work. Under that arrangement, all payment records contain only a single identification number, the so-called "provider number" assigned to each hospital at the time it is certified to participate in the medicare program. In some instances, where hospitals submit bills for their physicians billing may be done in the name of the head of the hospital department rendering the services. Payment records for such bills will contain the identification number assigned to the head of the department.

¹ Tabular data and explanation provided by Bureau of Health Insurance.

In either event, no information on the specific physician providing services and the amount paid him by medicare is available from payment records. Furthermore, the tabulation of payments to a physician receiving payments from a hospital as well as through his own bills would only reflect his own billings. Regardless of the billing arrangement, hospital-based physicians, including those billing directly cannot be obtained from SSA records. Identifying information and related payment data would need to be obtained from carriers and providers.

APPENDIX B

**Total Medicare-Medicaid Payments to Physicians Paid
\$25,000 or More Under Medicaid in 1968**

APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID IN 1968 ¹

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA	YYY20206Y	\$35, 908	\$73, 179	2
	YYY20217Y	67, 922	82, 194	2
	YYY20248Y	9, 790	34, 557	2
	YYY20249Y	158, 017	92, 950	2
	YYY20257Y	27, 106	65, 835	2
	YYY20262Y	79, 434	35, 925	2
	YYY20266Y	49, 123	54, 250	2
	YYY20283Y	43, 026	29, 935	2
	YYY20328Y	245, 619	173, 808	2
	YYY20353Y	28, 211	46, 149	2
	YYY20373Y	88, 363	143, 605	2
	YYY20394Y	84, 011	111, 358	2
	YYY20396Y	14, 603	88, 126	2
	YYY20418Y	193, 329	110, 465	2
	YYY20432Y	65, 539	118, 133	2
	YYY20475Y	18, 144	27, 915	2
	YYY20476Y	42, 181	79, 138	2
	YYY20485Y	55, 477	71, 989	2
	YYY20493Y	20, 063	30, 393	2
	YYY20494Y	51, 396	43, 537	2
	YYY20507Y	25, 299	49, 497	2
	YYY20516Y	25, 376	29, 414	2
	YYY20520Y	32, 005	25, 944	2
	YYY20521Y	92, 325	60, 883	2
	YYY20527Y	1, 651	50, 927	2
	YYY20538Y	52, 436	45, 285	2
	YYY20557Y	24, 014	106, 372	2
	YYY20563Y	30, 546	31, 603	1
	YYY20579Y	70, 103	101, 982	2
	YYY20582Y	20, 527	28, 912	2
	YYY20585Y	380, 469	95, 547	2
	YYY20589Y	46, 294	30, 064	2
	YYY20609Y	21, 782	32, 113	2
	YYY20612Y	7, 923	42, 312	2
	YYY20619Y	5, 125	44, 591	2
	YYY20641Y	38, 094	30, 934	2
	YYY20644Y	9, 413	34, 768	2
	YYY20662Y	11, 902	82, 035	2
	YYY20668Y	20, 631	42, 153	2
	YYY20677Y	915, 000	203, 559	2
	YYY20681Y	48, 903	104, 283	2
	YYY20682Y	53, 222	54, 155	2
	YYY20689Y	35, 816	68, 643	2
	YYY20789Y	14, 259	26, 937	2
	YYY20790Y	44, 522	49, 387	2
	YYY31936Y	30, 124	34, 779	2
	YYY31937Y	16, 333	36, 552	2
	YYY31950Y	6, 319	27, 690	2
	YYY31951Y	16, 930	30, 499	2

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	YYY31957Y	\$34, 422	\$46, 875	2
	YYY31964Y	16, 531	80, 488	2
	YYY31968Y	47, 886	31, 591	2
	YYY31980Y	3, 218	67, 776	2
	YYY32539Y	1, 494	44, 004	2
	YYY32611Y	15, 190	33, 393	2
	YYY32714Y	2, 631	25, 000	2
	YYY32716Y	7, 648	40, 401	2
	YYY32619Y	18, 112	52, 452	2
	YYY33578Y	24, 398	54, 425	2
	YYY33899Y	10, 282	42, 562	2
	YYY34193Y	32, 311	46, 144	2
	YYY34385Y	9, 637	40, 762	2
	YYY34512Y	10, 939	61, 396	2
	YYY34591Y	69	28, 243	2
	YYY35212Y	5, 528	56, 035	2
	YYY35534Y	4, 133	31, 425	2
	YYY35939Y	8, 379	31, 606	2
	YYY36241Y	3, 196	29, 816	2
	YYY36628Y	17	42, 559	2
	YYY37437Y	38, 082	56, 103	2
	YYY37644Y	155, 221	42, 253	2
	YYY37681Y	21, 969	60, 862	2
	YYY37914Y	6, 562	73, 643	1
	YYY38023Y	2, 691	33, 781	2
	YYY38117Y	7, 654	29, 946	2
	YYY40970Y	2, 198	30, 183	2
	YYY41275Y	5, 823	81, 437	2
	YYY41344Y	3, 514	26, 828	2
	YYY41753Y	6, 758	46, 056	2
	YYY41767Y	7, 853	48, 665	2
	ZZZP3001Z	3, 158	36, 594	2
	ZZZP3705Z	52, 208	62, 550	3
	ZZZP3823Z	1, 470	46, 338	3
	ZZZP3828Z	33, 995	75, 019	2
	ZZZP4301Z	76	63, 846	2
	ZZZP5701Z	26, 239	28, 316	2
	ZZZ20684Z	95, 215	147, 519	2
	ZZZ20685Z	183, 902	183, 349	2
	ZZZ20688Z	55, 992	58, 455	2
	ZZZ20690Z	19, 105	96, 925	2
	ZZZ20691Z	9, 222	49, 295	2
	ZZZ20702Z	143, 938	83, 833	2
	ZZZ20705Z	21, 256	28, 294	2
	ZZZ20710Z	93, 350	115, 247	2
	ZZZ20723Z	70, 745	95, 831	2
	ZZZ20725Z	6, 895	39, 514	2
	ZZZ20728Z	33, 465	176, 333	2
	ZZZ20731Z	7, 064	130, 567	2
	ZZZ20733Z	7, 605	26, 051	2
	ZZZ20734Z	13, 868	105, 269	2
	ZZZ20736Z	11, 631	52, 320	2
	ZZZ20737Z	10, 541	31, 142	2
	ZZZ20738Z	7, 057	27, 626	2
	ZZZ20739Z	3, 913	163, 982	2
	ZZZ20742Z	140, 879	27, 536	2
	ZZZ20744Z	36, 636	69, 103	2

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	ZZZ20745Z	\$41,927	\$45,033	2
	ZZZ20751Z	5,396	425,111	2
	ZZZ20756Z	52,116	66,614	2
	ZZZ20763Z	112,164	77,854	2
	ZZZ20770Z	14,921	187,681	2
	ZZZ20775Z	16,101	31,966	2
	ZZZ20797Z	181,641	94,787	2
	ZZZ30050Z	1,536	36,746	2
	ZZZ30132Z	41,209	52,407	2
	ZZZ30402Z	9,105	26,576	2
	ZZZ30561Z	37,541	79,429	2
	ZZZ30626Z	5,390	41,074	2
	ZZZ30895Z	2,225	76,526	2
	ZZZ30918Z	13,215	30,222	2
	ZZZ31264Z	37,734	120,026	2
	ZZZ31575Z	39,625	36,736	2
	ZZZ31863Z	15,156	156,575	2
	ZZZ31866Z	13,067	46,317	2
	ZZZ31867Z	10,217	47,857	2
	ZZZ31868Z	14,352	52,476	2
	ZZZ31871Z	14,701	42,759	2
	ZZZ31877Z	22,574	27,789	2
	ZZZ31884Z	13,782	44,728	2
	ZZZ31894Z	204,974	72,253	2
	ZZZ31898Z	4,855	86,962	2
	ZZZ31903Z	15,626	31,219	2
	ZZZ31910Z	18,796	157,743	2
	ZZZ31925Z	152	35,137	2
	ZZZ31940Z	245	54,437	3
	ZZZ31996Z	32,959	154,128	2
	ZZZ32578Z	4,734	25,339	2
	ZZZ32579Z	17,326	56,830	2
	ZZZ32641Z	4,550	175,619	2
	ZZZ32643Z	17,909	58,359	2
	ZZZ32694Z	8,789	125,912	2
	ZZZ32728Z	29,667	63,706	2
	ZZZ32877Z	32,049	208,506	2
	ZZZ32883Z	24,631	36,169	2
	ZZZ32884Z	30,293	49,195	2
	ZZZ32926Z	46,407	41,314	2
	ZZZ33603Z	1,981	36,829	2
	ZZZ33710Z	25,546	274,360	2
	ZZZ33812Z	6,474	113,710	2
	ZZZ33916Z	3,154	27,699	2
	ZZZ33917Z	1,930	36,999	2
	ZZZ33974Z	488	47,157	2
	ZZZ34000Z	83,266	52,263	2
	ZZZ34069Z	91,975	94,045	2
	ZZZ34082Z	337,132	124,015	2
	ZZZ34178Z	34,290	40,132	2
	ZZZ34250Z	16,396	69,857	2
	ZZZ34291Z	92,609	67,556	2
	ZZZ34333Z	4,232	26,288	2
	ZZZ34373Z	11,630	71,063	2
	ZZZ34637Z	913	83,831	2
	ZZZ34902Z	14,270	44,466	2
	ZZZ34946Z	7,379	31,980	2

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner (s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	ZZZ35064Z	\$15, 768	\$42, 357	2
	ZZZ35403Z	35, 797	35, 121	2
	ZZZ35835Z	1, 341	57, 234	2
	ZZZ36162Z	3, 746	60, 470	2
	ZZZ36642Z	5, 171	60, 932	2
	ZZZ36728Z	9, 100	71, 208	2
	ZZZ36857Z	6, 229	63, 199	2
	ZZZ36988Z	4, 931	26, 053	2
	ZZZ37278Z	14, 750	73, 967	2
	ZZZ37439Z	15, 528	55, 906	2
	ZZZ37717Z	11, 237	83, 096	2
	ZZZ37755Z	13, 222	31, 595	2
	ZZZ37764Z	9, 206	30, 722	2
	ZZZ37818Z	5, 705	68, 080	2
	ZZZ37962Z	17, 417	90, 236	2
	ZZZ38461Z	5, 198	47, 896	2
	ZZZ40090Z	7, 064	196, 068	2
	ZZZ40230Z	2, 249	32, 013	2
	ZZZ40640Z	2, 628	56, 436	2
	ZZZ40677Z	2, 007	30, 368	2
	ZZZ40963Z	13, 714	118, 185	2
	ZZZ41017Z	2, 710	102, 322	2
	ZZZ41087Z	11, 054	27, 091	2
	ZZZ41408Z	1, 072	40, 228	2
	ZZZ41783Z	18, 047	31, 845	2
	ZZZ41993Z	36	28, 376	3
	OOA021920	8, 994	29, 636	1
	OOA046960	12, 061	57, 292	1
	OOA047830	62, 385	38, 465	1
	OOA052810	12, 199	30, 070	1
	OOA053880	38, 897	42, 317	1
	OOA054220	11, 595	58, 793	1
	OOA056970	10, 221	26, 971	1
	OOA062180	13, 592	27, 945	1
	OOA067450	810	25, 646	1
	OOA068020	804	35, 196	1
	OOA069740	1, 092	25, 895	1
	OOA070570	734	32, 178	1
	OOA072570	16, 327	66, 995	1
	OOA073630	10, 386	54, 849	1
	OOA076430	11, 189	32, 441	1
	OOA076670	347	38, 699	1
	OOA077260	8, 198	25, 617	1
	OOA080780	7, 374	32, 501	1
	OOA081210	28, 473	41, 758	1
	OOA081320	3, 629	29, 420	1
	OOA085670	20, 140	30, 744	1
	OOA086890	6, 871	25, 994	1
	OOA087820	2, 460	41, 675	1
	OOA089850	11, 871	33, 510	1
	OOA090140	27, 329	47, 694	1
	OOA091230	5, 671	26, 766	1
	OOA092700	24, 246	49, 218	1
	OOA093670	46, 901	55, 892	1
	OOA094670	5, 944	33, 368	1
	OOA094840	1, 709	29, 188	1
	OOA095180	27, 398	25, 759	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOA097670	\$7, 694	\$101, 986	1
	OOA097990	12, 607	29, 082	1
	OOA100380	24, 230	105, 513	1
	OOA104210	25, 327	34, 321	1
	OOA104410	15, 630	38, 794	1
	OOA106720	11, 196	26, 311	1
	OOA107050	23, 258	29, 347	1
	OOA108980	5, 860	25, 542	1
	OOA109070	117, 223	28, 485	1
	OOA109400	3, 933	31, 571	1
	OOA109430	7, 076	28, 155	1
	OOA109910	31, 329	30, 787	1
	OOA111760	22, 343	27, 923	1
	OOA112460	44, 693	35, 265	1
	OOA114620	5, 891	34, 814	1
	OOA114630	19, 031	32, 686	1
	OOA116120	7, 415	29, 951	1
	OOA118560	9, 844	28, 071	1
	OOA120020	3, 083	37, 073	1
	OOA120330	29, 662	38, 405	1
	OOA121220	3, 097	27, 560	1
	OOA121310	28, 005	60, 201	1
	OOA122260	3, 571	44, 034	1
	OOA122490	12, 924	26, 648	1
	OOA126230	6, 849	25, 254	1
	OOA128940	25, 884	41, 218	1
	OOA130270	7, 705	28, 386	1
	OOA132250	14, 226	35, 030	1
	OOA134340	18, 662	34, 667	1
	OOA136890	9, 549	28, 813	1
	OOA137160	7, 274	34, 237	1
	OOA138010	3, 861	25, 151	1
	OOA140260	4, 126	28, 048	1
	OOA141620	6, 250	37, 277	1
	OOA142100	1, 366	51, 585	1
	OOA142250	13, 013	30, 731	1
	OOA142680	6, 458	43, 737	1
	OOA144220	24, 840	26, 870	1
	OOA144740	4, 529	49, 193	1
	OOA145420	3, 657	28, 148	1
	OOA146850	2, 982	34, 639	1
	OOA146890	1, 404	30, 189	1
	OOA150860	3, 099	39, 433	1
	OOA152270	1, 833	31, 159	1
	OOA153430	1, 683	27, 704	1
	OOA154200	4, 033	37, 991	1
	OOA155520	4, 692	47, 418	1
	OOA156290	1, 038	36, 447	1
	OOA157190	4, 236	31, 333	1
	OOA157880	6, 043	28, 221	1
	OOA157960	2, 296	33, 528	1
	OOA158200	2, 838	36, 571	1
	OOA158270	1, 590	30, 260	1
	OOA158570	14, 975	25, 446	1
	OOA159450	7, 157	30, 545	1
	OOA161320	4, 389	28, 214	1
	OOA162110	955	25, 309	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOA162780	\$4, 333	\$31, 471	1
	OOA162950	41, 125	132, 975	1
	OOA164240	14, 894	61, 187	1
	OOA164340	5, 194	28, 396	1
	OOA164990	8, 839	25, 966	1
	OOA165470	1, 344	30, 526	1
	OOA166600	991	98, 569	1
	OOA166670	7, 170	72, 191	1
	OOA167140	3, 914	29, 850	1
	OOA167380	3, 937	30, 914	1
	OOA167800	16, 253	33, 353	1
	OOA169170	1, 169	26, 176	1
	OOA169420	4, 475	74, 712	1
	OOA169500	8, 205	63, 149	1
	OOA170340	1, 998	37, 225	1
	OOA170390	7, 350	49, 859	1
	OOA171740	3, 808	29, 374	1
	OOA172850	5, 802	54, 884	1
	OOA173020	36, 020	33, 888	1
	OOA173370	6, 816	53, 572	1
	OOA173620	6, 125	31, 481	1
	OOA173970	6, 491	34, 470	1
	OOA174370	8, 434	29, 673	1
	OOA175190	12, 541	25, 594	1
	OOA175490	28, 167	71, 586	1
	OOA175560	6, 595	42, 705	1
	OOA177060	4, 573	34, 516	1
	OOA177290	19, 274	53, 557	1
	OOA177540	2, 295	31, 706	1
	OOA178170	1, 288	25, 509	1
	OOA179440	10, 455	39, 452	1
	OOA179950	106	42, 656	1
	OOA180270	11, 259	26, 364	1
	OOA181140	1, 158	35, 787	1
	OOA182960	9, 182	38, 651	1
	OOA183060	2, 567	38, 598	1
	OOA183720	13, 543	49, 117	1
	OOA183930	2, 971	38, 208	1
	OOA183940	18, 190	31, 067	1
	OOA184180	4, 213	40, 404	1
	OOA185900	14, 065	31, 802	1
	OOA186610	6, 455	26, 799	1
	OOA187300	12, 607	37, 433	1
	OOA187460	9, 419	30, 938	1
	OOA187550	24, 917	29, 261	1
	OOA188120	18, 587	31, 946	1
	OOA188420	6, 534	25, 233	1
	OOA188490	10, 453	33, 040	1
	OOA189050	4, 419	31, 589	1
	OOA189790	205	25, 181	1
	OOA189880	3, 327	37, 108	1
	OOA190000	22, 372	33, 280	1
	OOA190540	13, 765	66, 259	1
	OOA190900	5, 167	41, 126	1
	OOA191150	9, 048	40, 563	1
	OOA191330	2, 474	48, 012	1
	OOA191790	7, 174	34, 395	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

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**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOA192220	\$6, 780	\$33, 945	1
	OOA192340	15, 107	37, 074	1
	OOA192420	37, 269	29, 452	1
	OOA192800	2, 504	25, 663	1
	OOA193770	15, 311	42, 171	1
	OOA194870	5, 218	26, 790	1
	OOA195020	10, 725	29, 652	1
	OOA195340	28, 299	71, 666	1
	OOA195900	6, 144	46, 753	1
	OOA196140	9, 634	27, 838	1
	OOA196410	329	32, 328	1
	OOA196480	13, 419	29, 823	1
	OOA198000	4, 741	28, 252	1
	OOA198060	9, 611	35, 192	1
	OOA198240	157	36, 543	1
	OOA199090	15, 626	25, 132	1
	OOA199530	1, 110	32, 338	1
	YYY20580 Y	154, 295	28, 662	2
	YYY35938 Y	584	56, 728	2
	YYY38039 Y	4, 451	44, 897	2
	ZZZ34245Z	3, 928	201, 143	2
	ZZZ34753Z	18, 377	155, 488	2
	OOA071970	1, 484	63, 206	1
	OOA112540	7, 980	34, 791	1
	OOOG43020	29, 183	28, 772	1
	OOA201040	14, 016	34, 813	1
	OOA201080	17, 150	26, 344	1
	OOA201920	3, 993	80, 900	1
	OOA202010	631	59, 136	1
	OOA206400	350	47, 241	1
	OOA208620	2, 603	34, 029	1
	OOA209350	21	39, 255	1
	OOA209360	6, 233	39, 335	1
	OOA210640	5, 409	63, 079	1
	OOA212380	6, 764	32, 839	1
	OOA213470	3, 969	27, 115	1
	OOA213950	191	38, 446	1
	OOA214040	3, 758	42, 106	1
	OOA214200	5, 182	84, 811	1
	OOA215070	7, 431	35, 295	1
	OOA215550	5, 290	34, 589	1
	OOA216180	8, 497	27, 129	1
	OOA216980	3, 738	34, 227	1
	OOA218150	7, 130	78, 627	1
	OOA218700	4, 072	28, 477	1
	OOA219720	2, 504	46, 967	1
	OOA219820	1, 816	38, 904	1
	OOA220120	11, 844	32, 558	1
	OOA220440	5, 067	37, 426	1
	OOA221590	4, 679	41, 137	1
	OOA222070	11, 613	30, 933	1
	OOA223010	1, 583	26, 755	1
	OOA223910	8, 708	46, 007	1
	OOA224810	4, 713	71, 398	1
	OOA224960	2, 477	30, 504	1
	OOC102580	8, 137	47, 892	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID IN 1968 ¹—Continued

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOC104470	\$3, 430	\$39, 293	1
	OOC110780	5, 101	34, 202	1
	OOC111130	10, 948	42, 079	1
	OOC111360	2, 912	43, 634	1
	OOC113220	38, 652	45, 076	1
	OOC114770	8, 288	92, 968	1
	OOC114970	16, 153	48, 488	1
	OOC115390	8, 520	44, 960	1
	OOC117340	4, 171	25, 475	1
	OOC120650	3, 806	38, 038	1
	OOC125420	2, 683	27, 277	1
	OOC125860	8, 123	43, 767	1
	OOC126090	2, 819	30, 469	1
	OOC126530	1, 572	29, 966	1
	OOC127110	3, 779	25, 934	1
	OOC129050	3, 127	27, 233	1
	OOC130820	4, 221	35, 403	1
	OOC131600	65, 446	26, 754	1
	OOC134150	4, 729	29, 448	1
	OOC135080	9, 490	29, 259	1
	OOC138210	3, 675	35, 600	1
	OOC139560	6, 327	59, 143	1
	OOC141050	3, 430	43, 792	1
	OOC141840	4, 160	60, 926	1
	OOC146740	10, 156	43, 043	1
	OOC148280	14, 878	38, 135	1
	OOC149280	1, 297	40, 485	1
	OOC152170	1, 351	44, 679	1
	OOC154490	400	40, 481	1
	OOC158140	3, 394	30, 925	1
	OOC163450	21, 566	27, 868	1
	OOC166660	17, 670	31, 159	1
	COC167090	5, 849	27, 713	1
	OOC168680	8, 789	30, 729	1
	OOC172800	1, 800	60, 541	1
	OOC173660	4, 270	36, 746	1
	OOC173700	676	42, 132	1
	OOC175010	11, 318	49, 347	1
	OOC175550	5, 679	38, 489	1
	OOC176830	16, 846	51, 617	1
	OOC177160	52	56, 608	1
	OOC178020	100, 375	33, 079	1
	OOC178240	3, 219	45, 967	1
	OOC178200	4, 899	50, 937	1
	OOC178690	402	31, 684	1
	OOC180170	13, 645	32, 568	1
	OOC180510	8, 944	30, 944	1
	OOC180730	29, 942	57, 446	1
	OOC181340	64	30, 577	1
	OOC181790	17, 715	79, 610	1
	OOC182220	80, 202	29, 347	1
	OOC182260	2, 620	55, 637	1
	OOC183940	24, 359	27, 083	1
	OOC184770	24, 705	28, 234	1
	OOC186030	90, 736	29, 632	1
	OOC186280	1, 725	32, 434	1
	OOC188310	15, 755	42, 939	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOC189130	\$1, 676	\$45, 672	1
	OOC191760	55	47, 069	1
	OOC192550	939	40, 386	1
	OOC193200	6, 425	30, 373	1
	OOC193430	1, 973	62, 537	1
	OOC193540	15, 986	28, 633	1
	OOC194330	1, 200	27, 795	1
	OOC195160	5, 806	40, 118	1
	OOC196020	855	31, 634	1
	OOC196120	12, 955	36, 933	1
	OOC196680	6, 754	25, 429	1
	OOC197030	981	36, 511	1
	OOC199580	2, 167	30, 915	1
	OOC200430	22, 820	42, 451	1
	OOC200640	642	38, 708	1
	OOC202470	6, 847	38, 429	1
	OOC203820	13, 527	54, 974	1
	OOC203900	4, 326	25, 883	1
	OOC205730	782	53, 051	1
	OOC206420	2, 320	37, 323	1
	OOC207260	3, 556	25, 788	1
	OOC207450	4, 833	46, 307	1
	OOC207750	15, 229	37, 275	1
	OOC208360	558	70, 163	1
	OOC208570	4, 752	31, 354	1
	OOC208950	6, 681	30, 649	1
	OOC209010	2, 700	37, 036	1
	OOC209050	646	42, 403	1
	OOC209230	214	32, 698	1
	OOC209250	6, 462	25, 575	1
	OOC209860	1, 702	33, 450	1
	OOC209890	7, 741	26, 763	1
	OOC210410	784	33, 850	1
	OOC210670	12, 415	34, 459	1
	OOC210830	11, 673	41, 558	1
	OOC211530	14, 727	42, 010	1
	OOC213110	211	94, 565	1
	OOC213690	2, 744	39, 257	1
	OOC213730	5, 025	29, 675	1
	OOC213870	2, 162	34, 915	1
	OOC214960	6, 233	35, 999	1
	OOC215370	522	44, 776	1
	OOC215980	3, 059	38, 590	1
	OOC216280	12, 054	73, 214	1
	OOC216890	7, 407	39, 785	1
	OOC217400	606	38, 090	1
	OOC218970	737	55, 599	1
	OOC219640	22	30, 603	1
	OOC220610	1, 390	35, 646	1
	OOC220760	7, 568	39, 662	1
	OOC221000	13, 857	37, 008	1
	OOC222270	17, 187	34, 915	1
	OOC222500	8, 564	28, 668	1
	OOC224660	16, 341	34, 144	1
	OOC225120	10, 133	29, 724	1
	OOC225290	356	79, 730	1
	OOC225470	8, 915	45, 610	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	OOC225540	\$282	\$93, 238	1
	OOC229020	4, 684	26, 553	1
	OOC232000	3, 030	28, 814	1
	OOC232500	6, 523	26, 842	1
	OOC234180	6, 763	40, 631	1
	OOC234190	14, 103	33, 583	1
	OOC234360	5, 355	35, 994	1
	OOC234860	11, 147	46, 198	1
	OOC235240	6, 710	65, 985	1
	OOC237050	318	44, 690	1
	OOC238890	249	47, 450	1
	OOC239330	108	40, 527	1
	OOC243300	4, 492	28, 020	1
	OOC243620	378	49, 813	1
	OOC244720	10, 528	33, 731	1
	OOC244920	7, 806	42, 952	1
	OOC246670	3, 158	62, 227	1
	OOC246720	5, 235	28, 535	1
	OOC247820	10, 642	38, 027	1
	OOC248600	6, 047	25, 760	1
	OOC249560	896	34, 581	1
	OOC252450	39, 650	30, 203	1
	OOC252820	110	36, 196	1
	OOC257080	120	37, 272	1
	OOC257590	4, 337	25, 135	1
	OOC258100	11, 939	31, 293	1
	OOC259180	3, 997	152, 458	1
	OOC262690	3, 654	52, 881	1
	OOC262990	4, 136	30, 369	1
	OOC269390	144	26, 270	1
	OOC270440	12, 708	57, 160	1
	OOC271780	141	31, 122	1
	OOC271870	1, 042	35, 852	1
	OOC273030	3, 651	61, 504	1
	OOC273210	1, 937	32, 295	1
	OOC273310	10, 580	31, 020	1
	OOC279200	62	39, 926	1
	OOC279310	8, 836	26, 074	1
	OOC279560	59	32, 790	1
	OOC279680	3, 523	25, 338	1
	OOC282640	6, 587	37, 278	1
	OOC283650	1, 279	29, 154	1
	OOC287820	316	27, 001	1
	OOC295520	954	30, 317	1
	OOG100160	22	41, 018	1
	OOG101070	20, 827	46, 467	1
	OOG103730	15, 302	25, 124	1
	OOG107130	565	55, 177	1
	OOC84300	23, 755	25, 649	1
	OOC87460	13, 132	27, 535	1
	OOG107750	53	50, 285	1
	OOG115030	4, 375	51, 171	1
	OOG123380	19, 773	36, 051	1
	OOG126110	7, 930	25, 747	1
	OOG134610	14, 701	54, 845	1
	OOC50660	5, 598	40, 605	1
	OOC56050	25, 850	31, 740	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	000C58410	\$34, 213	\$28, 522	1
	000C67180	4, 842	79, 498	1
	000C68650	4, 302	31, 665	1
	000C70490	7, 604	28, 503	1
	000C73390	16, 709	64, 152	1
	000C76750	576	27, 204	1
	000C77380	8, 363	27, 467	1
	000C88570	5, 208	32, 096	1
	000C90660	14, 366	38, 720	1
	000C91640	50, 819	34, 339	1
	000C92500	15, 278	28, 733	1
	000C92760	12, 238	32, 786	1
	000C94840	2, 839	40, 775	1
	000C98010	8, 914	32, 513	1
	000C98270	4, 492	36, 679	1
	000G11340	2, 048	29, 128	1
	000G16590	9, 492	47, 126	1
	000G18390	1, 037	30, 388	1
	000G19090	5, 648	46, 883	1
	000G19190	18, 468	38, 866	1
	000G19220	14, 265	46, 353	1
	000G20400	1, 119	46, 335	1
	000G20570	4, 372	40, 007	1
	000G22590	63, 929	52, 783	1
	000G23180	7, 188	34, 262	1
	000G23650	6, 296	25, 123	1
	000G24770	5, 393	42, 411	1
	000G24970	9, 956	64, 369	1
	000G29810	11, 468	46, 885	1
	000G29920	2, 125	46, 056	1
	000G33680	7, 217	25, 708	1
	000G33990	377	35, 908	1
	000G34300	15, 483	34, 039	1
	000G34660	679	38, 284	1
	000G85150	12, 584	27, 228	1
	000G34920	4, 468	37, 330	1
	000G35170	3, 296	69, 572	1
	000G37100	1, 110	32, 648	1
	000G37110	977	26, 384	1
	000G40290	5, 753	31, 143	1
	000G40780	16, 336	65, 052	1
	000G44800	16, 968	26, 980	1
	000G45700	2, 499	39, 881	1
	000G46300	14, 013	26, 562	1
	000G48430	11, 365	27, 245	1
	000G48920	15, 494	29, 431	1
	000G55070	3, 858	37, 565	1
	000G56410	5, 825	51, 783	1
	000G56930	3, 542	27, 381	1
	000G62180	24	29, 509	1
	000G62480	21, 020	40, 480	1
	000G62700	1, 726	27, 180	1
	000G67780	20, 357	29, 082	1
	000G71590	17, 066	101, 061	1
	000G72400	132	30, 321	1
	000G74180	12, 723	34, 667	1
	000G75470	4, 233	36, 685	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	000G75600	\$7, 346	\$73, 414	1
	000G77590	7, 205	36, 553	1
	000G78200	1, 863	41, 117	1
	000G82140	8, 905	39, 010	1
	000G83890	12, 925	45, 772	1
	000G86670	1, 508	42, 218	1
	000G86710	11, 050	46, 015	1
	000G87070	18, 449	29, 204	1
	000G89810	5, 129	121, 188	1
	000G93000	1, 924	40, 984	1
	000G96440	7, 750	26, 890	1
	0000G2850	3, 913	50, 479	1
	0000G3350	45, 507	78, 900	1
	0000G5700	29, 349	43, 554	1
	0000G5960	23, 811	29, 837	1
	0000G7960	10, 994	28, 062	1
	0000G8910	10, 853	25, 712	1
	0000G9780	4, 475	31, 283	1
	00020C270	2, 923	26, 949	1
	00020C410	3, 846	40, 025	1
	0020A3150	7, 831	39, 912	1
	0020A4890	366	32, 265	1
	0020A6540	2, 771	28, 783	1
	0020A7670	6, 605	27, 439	1
	0020A8440	18, 263	69, 486	1
	0020A8520	1, 047	38, 042	1
	0020A8780	16, 022	27, 676	1
	0020A8960	1, 004	44, 533	1
	0020A9190	5, 852	49, 061	1
	0020A9990	6, 229	82, 567	1
	0020C1090	15, 015	46, 525	1
	0020C1240	39, 712	39, 676	1
	0020C1250	17, 914	45, 028	1
	0020C1280	20, 710	36, 847	1
	0020C1290	3, 652	46, 615	1
	0020C1310	18, 068	26, 181	1
	0020C1570	12, 347	25, 919	1
	020A10340	5, 173	61, 552	1
	020A10850	8, 545	88, 828	1
	020A11060	10, 408	27, 806	1
	020A12090	8, 313	64, 439	1
	020A12260	401	30, 928	1
	020A12890	4, 267	31, 116	1
	020A12930	6, 415	43, 990	1
	020A13110	4, 505	46, 079	1
	020A13430	38, 068	30, 211	1
	020A13670	6, 111	42, 588	1
	020A13990	2, 839	42, 984	1
	020A14000	3, 050	36, 390	1
	020A14010	6, 904	25, 875	1
	020A14020	3, 483	26, 096	1
	020A14620	19, 623	38, 684	1
	020A14810	15, 085	37, 944	1
	020A14860	17, 378	90, 868	1
	020A14900	11, 178	26, 471	1
	020A15010	4, 008	27, 161	1
	020A15040	15, 956	38, 847	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	O20A15680	\$53, 591	\$26, 354	1
	O20A15760	10, 006	36, 422	1
	O20A15790	17, 565	62, 144	1
	O20A15980	3, 746	65, 103	1
	O20A16390	9, 875	30, 482	1
	O20A16430	9, 346	54, 632	1
	O20A16770	6, 060	79, 126	1
	O20A16820	18, 505	36, 095	1
	O20A17260	9, 022	82, 333	1
	O20A17420	5, 864	42, 369	1
	O20A17450	10, 791	52, 880	1
	O20A17700	1, 674	30, 735	1
	O20A17880	8, 409	41, 275	1
	O20A18690	4, 583	62, 197	1
	O20A18830	8, 474	35, 821	1
	O20A18930	54, 437	72, 085	1
	O20A19710	4, 911	35, 469	1
	O20A19900	15, 158	84, 066	1
	O20A19990	1, 477	27, 258	1
	O20A20220	13, 190	25, 444	1
	O20A20460	3, 973	47, 358	1
	O20A20480	19, 272	28, 990	1
	O20A20530	7, 542	26, 033	1
	O20A20570	1, 796	28, 379	1
	O20A20790	2, 033	28, 130	1
	O20A20880	10, 688	49, 456	1
	O20A20930	10, 975	29, 866	1
	O20A21130	1, 500	26, 822	1
	O20A21340	27, 240	40, 044	1
	O20A21360	3, 099	91, 553	1
	O20A21470	26, 774	35, 191	1
	O20A21750	7, 063	57, 602	1
	O20A21810	1, 317	48, 206	1
	O20A22010	6, 908	29, 544	1
	O20A22070	1, 068	27, 407	1
	O20A22330	3, 152	29, 168	1
	O20A22800	19, 541	27, 897	1
	O20A22960	3, 538	60, 256	1
	O20A23380	4, 427	31, 326	1
	O20A23400	6, 875	25, 761	1
	O20A23610	2, 682	36, 532	1
	O20A23690	16, 284	42, 019	1
	O20A23740	7, 537	25, 129	1
	O20A23770	442	49, 318	1
	O20A24000	1, 014	27, 769	1
	O20A24080	2, 267	96, 237	1
	O20A24090	14, 068	39, 134	1
	O20A24190	2, 843	38, 797	1
	O20A24200	2, 253	38, 398	1
	O20A24500	9, 480	27, 802	1
	O20A24710	4, 596	58, 039	1
	O20A24790	12, 972	27, 476	1
	O20A24970	2, 427	38, 434	1
	O20A25230	4, 126	29, 891	1
	O20A25390	1, 197	36, 736	1
	O20A25750	3, 324	84, 254	1
	O20A25950	10, 092	50, 248	1

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² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
CALIFORNIA—Continued	O20A26200	\$17, 364	\$40, 046	1
	O20A26370	3, 948	41, 118	1
	O20A26400	1, 327	29, 637	1
	O20A26650	10, 344	31, 213	1
	O20A26730	1, 668	57, 995	1
	O20A26970	4, 507	49, 380	1
	O20A27740	3, 664	61, 724	1
	O20A29260	3, 429	96, 907	1
	O20A29340	2, 603	38, 955	1
	O20A29750	3, 771	25, 895	1
	O20A30430	5, 329	99, 857	1
	O20A30440	5, 800	41, 553	1
	ZZZ20696Z	8, 406	31, 540	4
	ZZZ37127Z	8, 889	32, 192	4
	ZZZ37963Z	6, 952	32, 375	1
	ZZZ20776Z	38, 957	32, 639	2
	ZZZ31873Z	1, 994	33, 645	2
	ZZZ32705Z	7, 958	33, 770	2
	ZZZ35675Z	25, 334	33, 804	1
	ZZZ41386Z	8, 238	34, 106	2
	YYY319365	30, 124	34, 779	2
	ZZZ33612Z	14, 863	132, 921	1
	ZZZ39046Z	22, 970	33, 300	2
	YYY20619Y	5, 125	44, 591	2
	ZZZ31015Z	14, 757	33, 586	1
COLORADO	000060042	326, 262	39, 526	3
	000060011	144, 195	39, 740	3
			40, 892	3
CONNECTICUT	A001462	847	28, 109	1
	A003521	1, 680	26, 108	1
	A004085	15, 489	32, 352	1
	A004685	10, 842	27, 043	1
	A007354	277	29, 689	1
	A008510	6, 345	27, 577	1
	A008794	4, 277	36, 496	1
	A010891	123	31, 115	1
	000000782	55, 595	31, 593	2
	000006521	1, 441	36, 700	1
DELAWARE	111561P	1, 273	30, 404	2
	105194S	29, 519	29, 360	1
	105565D	36, 444	32, 237	1
FLORIDA	106389C	31, 576	31, 342	1
	107082B	45, 969	37, 114	1
	107496H	29, 234	45, 354	1
GEORGIA	110546G	27, 962	32, 262	1
	104924W	26, 594	25, 797	1
	111054W	26, 594	25, 797	1
ILLINOIS	001607080	610	98, 614	1
	003622192	397	43, 554	1
	001600087	864	27, 149	1
	001600157	26, 044	55, 071	1
	001601878	14, 748	25, 015	1
	001601960	800	33, 595	1
	001601962	667	78, 426	1
	001602095	1, 702	30, 357	1
	001602932	1, 436	56, 827	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
ILLINOIS—Continued	001603063	\$1, 505	\$36, 500	1
	001603635	644	25, 496	1
	001603648	457	25, 672	1
	001603900	1, 065	37, 980	1
	001603975	1, 080	47, 308	1
	001603955	509	33, 258	1
	001604106	6, 676	98, 371	1
	001604107	83	43, 684	1
	001604177	32, 206	27, 299	1
	001604230	1, 813	87, 643	1
	001604331	221	54, 446	1
	001604499	234	32, 220	1
	001604589	9, 023	66, 227	1
	001604646	3, 727	52, 850	1
	001604732	3, 495	64, 404	1
	001604737	4, 148	83, 800	1
	001604785	126	35, 600	1
	001604796	8	51, 847	1
	001604910	82	72, 574	1
	001604947	52	33, 327	1
	001604962	4, 306	56, 098	1
	001604991	428	95, 729	1
	001605948	99	25, 947	1
	001606038	4, 159	35, 700	1
	001606328	1, 956	28, 860	1
	001606548	1, 059	25, 688	1
	001606827	19, 517	31, 404	1
	001606861	3, 427	62, 420	1
	001606954	1, 968	30, 467	1
	001607468	1, 789	65, 825	1
	001608910	8, 698	73, 849	1
	001609173	4, 376	39, 481	1
	001609650	12, 959	60, 534	1
	001609686	20, 471	78, 111	1
	001609796	518	36, 300	1
	001609798	1, 702	41, 992	1
	001609945	648	58, 081	1
	001620047	122	57, 700	1
	001623483	637	41, 313	1
	001623750	3, 084	73, 760	1
	001624125	44	47, 811	1
	001624329	1, 663	33, 600	1
	001625015	1, 076	40, 341	1
	001628971	6, 200	41, 036	1
	001629998	219	30, 784	1
	021600002	9, 245	54, 385	1
	021600142	10, 972	79, 593	1
	021600197	550	103, 698	1
	021600310	1, 263	57, 311	1
	021600311	264	39, 170	1
	021600355	890	42, 266	1
	021600402	1, 339	35, 400	1
	021600470	620	36, 120	1
	021600521	1, 268	32, 332	1
	021600605	3, 126	104, 872	1
	021600682	2, 644	102, 357	1
	021620201	4	47, 551	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
ILLINOIS—Continued	216000152	\$30	\$44, 781	1
	3622291	6, 454	62, 677	1
	3622621	28, 549	30, 404	1
	3624975	222	27, 533	1
	3625841	2, 804	29, 118	1
	3628581	9, 024	33, 800	1
	3629036	1, 737	39, 086	1
	3629067	2, 377	25, 236	1
	3629959	1, 195	25, 565	1
	3634169	1, 983	91, 349	1
	3636516	12, 788	46, 156	1
	3636553	25	110, 806	1
	3636793	3, 873	44, 443	1
	3638162	3, 261	62, 207	1
	3638563	659	52, 238	1
INDIANA	000047171	26, 216	36, 815	1
	000047539	22, 288	32, 850	1
	000004385	11, 796	42, 865	1
	000083141	30, 719	25, 859	1
IOWA	000047434	1, 843	33, 576	1
	037077B49	55, 266	72, 594	2
	020177333	18, 300	30, 536	1
KANSAS	050277977	6, 844	33, 200	1
	000002041	5, 965	40, 289	2
	000003763	57, 105	27, 917	2
	000003842	179, 291	42, 683	2
	000002419	1, 191	25, 215	1
	000002791	9, 059	27, 401	1
	000003863	47, 412	25, 705	2
	000003707	22, 861	29, 453	2
	000003858	208, 852	27, 033	2
	000001896	7, 891	37, 679	1
	000001726	17, 839	31, 822	1
	000003702	120, 068	29, 912	2
	000003719	364, 632	94, 256	2
KENTUCKY	4374942TD	44, 053	41, 626	1
	7385365BA	5, 468	119, 768	1
	2983494JF	8, 764	74, 973	1
	2983494RW	571	73, 374	1
	3372305BM	13, 031	28, 777	1
	3372502AS	27, 504	103, 255	1
	3372512ES	9, 943	26, 015	1
	3373249RE	1, 691	84, 979	1
	3412999RA	4, 624	108, 490	1
	3482206MR	13, 959	32, 521	1
	3483381GS	999	28, 984	1
	3483966RH	1, 680	32, 821	1
	3485171CM	1, 052	39, 217	1
	3657530EB	29, 518	31, 533	1
	3762221MW	7, 888	41, 875	1
	3765363HP	9, 275	53, 680	1
	3782131DM	1, 714	29, 967	1
	4276701DS	12, 731	42, 030	1
	4323461LE	44, 911	28, 391	1
	4362441LW	3, 048	29, 970	1
	4363532CS	3, 324	38, 426	1
	4376701WC	54, 732	31, 646	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
KENTUCKY—Continued	4567758CB	\$10, 514	\$26, 229	1
	4642941CN	1, 617	26, 382	1
	4732646TC	2, 245	51, 647	1
	4762520AP	2, 575	39, 816	1
	5263346DM	22, 910	44, 555	1
	5263636RW	15, 045	38, 273	1
	5284545PB	7, 768	28, 640	1
	5463113WC	4, 600	28, 180	1
	5464035JC	2, 824	96, 345	1
	5464566RH	10, 354	55, 818	1
	5731800PB	3, 584	29, 780	1
	5732646HB	8, 551	35, 403	1
	5732966HB	368	39, 731	1
	5734520WS	654	26, 007	1
	5822344AR	20, 074	40, 302	1
	5845572IG	9, 915	39, 753	1
	5935023RS	10, 372	31, 498	1
	5982116JB	7, 705	27, 977	1
	5982116WB	14, 116	38, 167	1
	6337585LA	5, 080	30, 675	1
	6665103RC	13, 161	57, 649	1
	6665354PS	7, 670	58, 755	1
	6683200PM	5, 817	80, 840	1
	6722313GB	1, 156	28, 750	1
	6722314MW	3, 948	27, 055	1
	7234444CT	1, 704	40, 527	1
	7267664CD	31, 951	28, 705	1
	7434124GB	3, 775	30, 476	1
	7493456LH	652	35, 715	1
	7855811GW	1, 766	37, 705	1
	7893511FB	19, 527	37, 837	1
	7893511GP	20, 427	53, 878	1
	7893511JT	6, 825	32, 026	1
	7894804FP	13, 994	27, 235	1
	7895351AC	8, 763	32, 192	1
	8322171AN	7, 753	69, 448	1
	8322171PO	8, 592	48, 420	1
	8322171EM	26, 999	45, 626	1
	8472121IW	13, 922	42, 996	1
	8643371JS	46, 569	66, 262	1
	8644444CW	6, 338	28, 115	1
	8645361RC	18, 474	42, 468	1
	8855394JF	2, 852	26, 495	1
	8954795DH	397	40, 015	1
	9272061FL	446	49, 365	1
	2482801FW	14	29, 642	1
	2484862RR	11, 137	27, 605	1
	2743543ES	376	29, 770	1
	2853221LM	1, 275	46, 021	1
	2918070RL	10, 888	29, 042	1
LOUISIANA	016000000	15, 756	34, 850	1
	028540000	23, 830	33, 506	1
	016630000	38, 744	46, 437	1
	017060000	26, 773	34, 560	1
	024610000	12, 300	29, 528	1
	016030000	9, 048	25, 287	1
	075600000	19, 654	28, 492	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
LOUISIANA—Continued	016740000	\$12, 679	\$46, 094	1
	065510000	19, 193	29, 822	1
	010010000	29, 453	29, 938	1
MARYLAND	000007642	8, 057	49, 610	1
	000004314	30	46, 781	1
	000004688	217	45, 345	1
	000006554	781	44, 456	1
	000005338	2, 715	37, 855	1
	000006920	677	37, 285	1
	000006281	15, 823	37, 003	1
	000001804	825	36, 819	1
	000006350	2, 062	35, 923	1
	000003124	4, 069	34, 704	1
	000006917	24	33, 132	1
	000006060	1, 896	31, 822	1
	000008433	1, 507	31, 750	1
	000004436	2, 923	29, 955	1
	000002017	7, 179	29, 658	1
	000001609	351	28, 451	1
	000006172	408	26, 616	1
	000005104	860	25, 634	1
	000002000	445	25, 386	1
	000007550	5, 568	25, 339	1
MASSACHUSETTS	M02620RU	14, 695	43, 402	2
	N51016LI	19, 513	43, 402	2
	N51270KO	1, 556	35, 026	1
	N51274SK	276	35, 451	1
	B26012LE	51, 007	29, 574	1
	M10290LE	9, 909	29, 574	2
	M02104ST	4, 166	30, 901	1
	M03781WI	19, 049	33, 356	1
	X01809KA	256	25, 081	1
	B26111CO	15, 775	25, 210	1
	X02571MC	228	26, 139	2
MICHIGAN	000H26000	103, 062	50, 388	2
	000B46000	186, 040	55, 689	2
	001829441	5, 000	25, 091	1
	000826534	24, 279	27, 765	1
	000C76000	59, 470	45, 092	2
	000824393	25, 371	39, 630	1
	005820345	2, 301	32, 801	1
	000820830	3, 866	52, 846	1
	002250305	3, 113	34, 601	1
	000828036	823	27, 089	1
	001825195	9, 745	26, 122	1
	000112018	7, 419	32, 164	1
	000820330	14, 517	26, 178	1
	002820947	2, 763	100, 508	1
	000250683	6, 396	27, 997	1
	000825208	749	44, 318	1
	000745374	16, 358	33, 510	1
	000826289	2, 006	107, 758	1
	000825118	27, 554	37, 259	1
	000823910	567	47, 245	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
MICHIGAN—Continued	000824667	\$1, 096	\$122, 464	1
	000119590	6, 809	25, 152	1
	000637337	5, 128	33, 520	1
	000256464	3, 307	33, 208	1
	000H21026	928, 261	266, 240	3
	000824559	31, 462	51, 475	1
	000829212	5, 093	25, 721	1
	000826947	1, 766	33, 132	1
	000823913	4, 489	34, 286	1
	000633340	580	27, 467	1
	000828292	28, 552	35, 406	1
	000825427	6, 875	34, 815	1
	000H26031	38, 525	39, 872	2
	000507505	132	32, 200	1
	000H36000	40, 279	42, 066	2
	000H26105	28, 489	31, 865	2
	000613846	7, 376	48, 620	1
	004822879	156, 927	49, 687	1
	000825638	4, 392	90, 185	1
	000824554	47, 504	112, 451	1
	000635430	52, 965	28, 386	1
	000820061	32, 034	42, 661	1
	000G31000	116, 700	72, 456	3
	000252261	7, 354	27, 221	1
	000116945	14, 695	169, 061	1
	000H11005	331, 638	296, 416	3
	000829458	4, 861	42, 804	1
	000825082	4, 889	26, 463	1
	000820619	38, 081	25, 541	1
	000H21063	138, 683	93, 001	3
	000800968	20, 666	26, 966	1
	000824960	2, 346	36, 801	1
	005821795	292	25, 047	1
	005820050	7, 369	63, 767	1
	005821253	4, 863	63, 954	1
	005822252	26, 430	203, 402	1
	005820490	3, 060	28, 510	1
	005820657	1, 327	27, 412	1
	005820487	19, 153	32, 424	1
	005821441	108, 526	29, 811	1
	005250347	14, 809	47, 308	1
	005730260	1, 883	31, 609	1
	005250942	14, 525	35, 015	1
	005821221	2, 926	36, 418	1
	005610817	8, 180	29, 185	1
	005250418	2, 120	40, 469	1
	005820846	1, 159	31, 894	1
	005820650	241	33, 639	1
	008820680	2, 900	29, 915	1
	005821355	1, 618	31, 125	1
	005820213	2, 705	26, 724	1
	005652174	55, 137	41, 718	1
	005731968	42	24, 999	1
	005130265	3, 179	27, 271	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
MINNESOTA	011795998	\$18, 890	\$40, 155	1
	011796183	3, 874	36, 732	1
	011798010	3, 344	76, 599	1
	041610026	10, 568	33, 915	1
	112797712	21, 250	33, 736	1
	112797942	563	47, 631	1
	301797919	215	36, 732	1
	700610000	54, 556	33, 426	2
	700610001	20	33, 426	2
	700610020	258, 340	38, 891	2
	700610025	92, 904	46, 656	2
	700610030	183, 939	33, 553	2
	700610035	232, 877	71, 340	2
	700610040	136, 780	85, 067	2
	700610045	18, 941	33, 017	2
	700610135	38, 810	41, 261	2
	700610280	26, 915	33, 071	2
	700610380	329, 026	35, 625	2
	700610250	25, 122	69, 975	2
MISSOURI	000006385	23, 383	36, 984	1
	00006197	9, 973	27, 268	1
	000000211	6, 210	26, 030	1
	000000627	468	27, 278	1
	000004520	17, 558	27, 596	1
	000004533	28, 175	38, 494	1
	000004534	26, 283	40, 956	1
	000004986	20, 385	30, 232	1
	000004987	30, 640	34, 793	1
	000005013	12, 116	53, 470	1
	000005018	12, 945	32, 736	1
	000005081	48, 317	47, 100	1
	000005158	34, 359	25, 211	1
	000005482	10, 901	36, 636	1
	000005498	41, 484	41, 596	1
	000006133	8, 344	27, 085	1
	000006244	17, 895	29, 092	1
	000006255	23, 757	30, 981	1
	000006273	37, 312	34, 362	1
	000006342	7, 820	34, 196	1
MONTANA	000008578	16, 892	27, 360	1
	000000672	27, 393	30, 137	1
NEBRASKA	000250746	5, 879	44, 053	1
	000250420	6, 482	38, 074	1
	000250221	85, 871	32, 249	2
NEVADA	BBDPX	400	26, 162	1
	BBCJZ	25, 826	28, 294	1
NEW JERSEY	210715683	4, 842	25, 664	1
	154228392	19, 544	31, 464	1
	136144530	21, 362	52, 756	1
	143247994	13, 714	37, 826	1
	102228445	4, 581	32, 897	1
NEW MEXICO	154148268	3, 602	43, 778	1
	2100991	2, 122	45, 082	1
	2104832	55	57, 607	1
	2105602	3, 228	26, 661	1
	2100973	77	29, 904	1
	2109194	208	31, 309	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW MEXICO—Continued	2105097	\$3, 282	\$37, 083	2
	2104933	3, 709	-----	2
	2100175	848	-----	2
	2110057	141	-----	2
	2108489	355	27, 952	1
	2300935	1, 121	44, 639	1
	2300926	86	25, 252	1
	2300348	45	39, 031	1
	2300724	6, 727	39, 429	1
	2300559	3, 022	27, 160	1
	2300265	2, 841	40, 394	1
	2300274	1, 902	43, 768	1
	2301154	5, 609	51, 539	1
	2300412	5, 581	35, 678	1
	2300687	1, 865	52, 509	1
	2300375	35	54, 332	1
	2300971	1, 791	49, 568	1
	2300696	1, 771	49, 030	1
	2300917	6, 324	66, 209	1
	2370088	7, 179	38, 634	2
	2370006	1, 029	272, 945	2
	2400035	17, 886	27, 162	1
	2370198	6, 740	27, 896	1
NEW YORK	0000F0006	189, 709	50, 714	3
	0000A5901	71, 064	190, 763	4
	0000A5917	68, 748	97, 393	4
	0000B6900	71	85, 500	4
	0000B6914	1, 539	108, 202	4
	0000B7943	304	42, 876	4
	0000C4427	1, 128	38, 425	4
	0000C4493	100	82, 085	2
	0000C5435	16, 913	25, 657	4
	0000C5450	2, 904	47, 982	4
	0000C5839	207	73, 339	1
	0000C6466	172	57, 182	1
	0000C6469	32	130, 565	4
	0000C7805	120	28, 104	1
	0000C7834	12	67, 056	1
	0000C7858	27	27, 024	1
	0000C8804	96	42, 843	1
	0000C8808	48	28, 402	1
	0000C8812	48	41, 294	1
	0000D0079	112	25, 579	1
	0000D0114	128	155, 134	1
	0000D0173	44	27, 297	1
	0000D0178	240	33, 050	1
	0000D0299	292	29, 322	1
	0000E5103	7, 641	86, 888	4
	0000E5112	8, 652	36, 346	3
	0000F0008	128, 360	59, 668	3
	0000E5113	21, 237	60, 487	4
	0000F0012	41, 739	1, 027, 592	3
	0000D1588	14	363, 101	1
	0000F0014	434, 251	2, 345, 132	3
	0000F0019	21, 876	30, 973	3
	0000F0024	1, 680	39, 989	3

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	0000F0027	\$4,367	\$759,082	2
	0000G5302	65,555	41,165	2
	0000H0009	39,237	49,632	3
	0000H0012	124,220	2,345,132	3
	0000H0017	4,745	102,016	3
	0000H0024	62,138	1,356,978	1
	0000H0028	21,882	66,172	3
	0000H0046	49,620	672,431	3
	0000H0059	51,049	192,193	3
	0000H0063	29,420	227,475	3
	0000H0064	22,458	174,288	3
	0000H0068	15,150	95,455	3
	0000H0069	15,145	318,405	3
	0000H0070	12,139	74,700	3
	0000H0072	25,165	97,464	1
	0000H0083	5,460	110,193	3
	0000H0089	3,629	28,058	3
	0000H0099	5,042	95,005	3
	0000H0101	35,059	189,884	3
	0000H0119	68,517	105,803	3
	0000H0120	43,209	291,287	3
	0000H0124	14,511	125,329	3
	0000H0156	4,533	114,317	3
	0000H0160	27,835	197,762	3
	0000H0167	19,327	27,681	3
	0000H0194	19,057	601,047	3
	0000H0230	13,446	30,973	3
	0000H0233	8,086	1,027,592	3
	0000H0236	23,254	705,967	3
	0000H0247	1,807	109,264	3
	0000H0270	11,771	52,834	3
	0000H0289	10,973	43,463	3
	0000H0290	99,231	82,377	3
	0000H0306	26,362	154,780	2
	0000H0310	4,789	362,911	3
	0000H5101	22	50,714	3
	0000L8093	7,539	26,363	4
	0000L8187	706	53,417	4
	0000P0066	46	88,772	1
	0000P0244	129	34,877	1
	0000P0272	33	31,922	1
	0000P0303	588	45,332	1
	000014803	45,164	47,030	1
	0000P0315	100	27,108	1
	0000P0365	208	32,376	1
	0000P0455	48	83,926	1
	0000P0592	1,158	28,553	1
	0000P0675	124	26,548	1
	0000P0806	80	28,886	1
	0000P0859	320	30,353	1
	0000P0917	280	43,456	1
	0000P0937	4,049	89,628	1
	0000P0974	243	31,775	1
	0000P1143	12	83,771	1
	0000P1629	84	80,139	1
	0000P1854	17	56,828	1
	0000P2178	190	26,754	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	0000P2226	\$5	\$69,348	1
	0000P2283	129	29,019	1
	0000Z0318	25,255	38,930	3
	0000Z0328	38,060	45,919	3
	000000058	6,486	49,034	1
	000000109	20,185	41,798	1
	000000164	15,012	111,869	1
	000000239	2,304	26,595	1
	000000398	3,361	36,878	1
	000000634	25,992	31,046	1
	000001831	2,859	49,096	1
	000002340	1,695	26,172	1
	000002560	1,453	36,648	1
	000002837	57,383	51,873	1
	000003466	1,572	49,327	1
	000003637	628	33,692	1
	000003729	56	44,068	1
	000003910	8,114	46,296	1
	000003940	1,471	60,290	1
	000004128	4,881	55,328	1
	000004207	2,847	31,034	1
	000004415	27,399	27,783	1
	000004450	7,040	46,363	1
	000004563	5,591	34,982	1
	000004612	8,892	32,870	1
	000004825	9,784	65,380	1
	000005136	7,743	31,296	1
	000005454	280	74,615	1
	000005516	18,564	32,432	1
	000005517	6,000	41,284	1
	000006131	38,892	63,206	1
	000007019	2,321	31,582	1
	000009662	3,549	37,136	1
	000010307	9,675	32,566	1
	000010865	NA	45,308	1
	000010915	NA	31,923	1
	000011492	1,135	69,577	1
	000011622	2,995	76,384	1
	000012022	6,759	82,076	1
	000012210	5,336	68,344	1
	000012612	400	41,421	1
	000012878	846	32,912	1
	000012908	33	63,436	1
	000013213	226	27,799	1
	000013249	1,931	67,163	1
	000013636	6,110	32,409	1
	000013762	1,572	30,463	1
	000015220	420	38,101	1
	000015328	3,573	48,053	1
	000015354	4,021	45,926	1
	000015364	2,585	36,195	1
	000015441	1,015	25,794	1
	000015444	10	43,725	1
	000015473	2,889	55,306	1
	000015981	941	51,294	1
	000016413	110	40,201	1
	000016420	698	63,417	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	000016481	\$672	\$110,592	1
	000016506	3,271	66,683	1
	000016835	3,412	41,330	1
	000017478	1,612	28,862	1
	000017850	568	101,604	1
	000018224	1,929	73,609	1
	000018618	1,352	60,856	1
	000018944	16,528	27,503	1
	000019049	10,936	59,024	1
	000019328	311	97,331	1
	000019359	7,058	31,636	1
	000019366	4,249	84,525	1
	000019671	372	40,795	1
	000019728	13,366	27,828	1
	000019984	856	28,489	1
	000020006	2,188	25,502	1
	000020142	5,008	34,974	1
	000020198	10,090	32,222	1
	000020288	2,109	29,129	1
	000020313	1,016	36,078	1
	000020374	17,688	30,875	1
	000020378	6,749	37,096	1
	000020410	1,558	31,002	1
	000020416	28,914	34,804	1
	000020419	7,952	48,170	1
	000020453	9,138	34,410	1
	000020639	263	31,347	1
	000020678	2,058	30,891	1
	000020783	642	42,899	1
	000020819	36,072	33,719	1
	000020893	1,045	65,743	1
	000021054	6,764	38,292	1
	000021068	7,607	28,051	1
	000021305	2,893	45,439	1
	000021376	13,769	47,231	1
	000021513	4,743	78,929	1
	000021557	23,966	58,517	1
	000021709	678	43,309	1
	000021831	1,063	32,927	1
	000021833	282	45,213	1
	000021922	41,770	30,487	1
	000021924	1,892	50,792	1
	000021938	1,209	31,615	1
	000022038	1,029	27,018	1
	000022125	526	29,986	1
	000022259	12,550	34,405	1
	000022347	4,209	72,078	1
	000022356	1,962	52,197	1
	000037558	2,727	27,056	1
	000049103	1,456	37,259	1
	000055636	382	41,790	1
	000070083	97,548	46,979	1
	000043534	1,667	43,546	1
	0000C6841	54	28,974	1
	0000C6853	32	292,304	1
	0000F0021	5,051	601,047	2
	0000F0022	125,126	601,047	2

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	0000F0023	\$105,565	\$601,047	2
	0000H0026	29,718	102,688	3
	000017553	41,880	55,706	1
	000005091	1,838	27,825	1
	000005128	18,159	49,031	1
	000015142	51,365	28,703	1
	000015705	41,276	71,684	1
	000016282	21,365	54,861	1
	000016314	10,314	45,194	1
	000016482	409	35,022	1
	000013211	252	27,872	1
	000075144	40	28,420	1
	000037968	755	25,409	1
	000065064	7,158	31,031	1
	000079876	1,136	38,193	1
	000070074	11,838	29,144	1
	000015744	3,679	40,776	1
	000070088	11,450	38,181	1
	000070098	17,442	38,540	1
	000037081	800	54,371	1
	000012984	39,093	25,357	1
	000015533	2,892	39,538	1
	000047082	7,217	25,821	1
	000014530	5,334	29,709	1
	000067137	2,400	37,530	1
	000067258	4,471	43,398	1
	000067281	1,416	25,014	1
	000053143	2,316	50,116	1
	000037648	1,206	28,942	1
	000016065	18,109	29,996	1
	000013945	92	26,366	1
	000053465	3,852	42,790	1
	000037945	4,102	42,402	1
	000027269	1,770	35,652	1
	000012617	1,706	25,942	1
	000053102	511	28,160	1
	000053501	2,073	25,313	1
	000014366	3,692	31,815	1
	000037882	3,572	26,705	1
	000053555	6,435	65,910	1
	000038493	954	29,539	1
	000053563	13,104	41,632	1
	000014660	6,509	51,445	1
	000048041	3,850	46,680	1
	000048057	33,796	83,548	1
	000048691	9,350	46,260	1
	000038173	3,178	28,926	1
	000054625	2,771	29,902	1
	000055668	6,638	32,301	1
	000054930	7,038	25,925	1
	000055274	6,330	30,934	1
	000054599	1,514	28,616	1
	000019132	593	31,547	1
	000054106	4,881	59,424	1
	000055247	7,517	40,677	1
	000010669	1,718	27,383	1
	000017018	6,167	28,174	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	000054628	\$ 549	\$25,843	1
	000054568	28,122	55,643	1
	000064004	12,125	37,816	1
	000018541	1,149	29,194	1
	000064044	11,241	37,860	1
	000071064	523	35,309	1
	000053608	28,090	30,120	1
	000069045	21,530	31,548	1
	000022391	19,054	29,818	1
	000022392	200	31,491	1
	000022410	4,328	34,955	1
	000022424	24	30,784	1
	000022671	1,293	26,431	1
	000022761	8,419	64,834	1
	000022933	3,836	26,951	1
	000022969	560	33,614	1
	000023095	6,583	26,598	1
	000023116	8,085	113,781	1
	000023317	4,028	142,208	1
	000023345	122	42,365	1
	000023672	1,178	28,739	1
	000023736	5,474	59,614	1
	000023757	45,428	26,608	1
	000023779	30	39,336	1
	000024193	325	36,199	1
	000024201	252	39,960	1
	000024223	42	61,534	1
	000024255	4,827	31,565	1
	000024268	13,924	46,415	1
	000024271	4,172	53,584	1
	000024425	1,509	32,009	1
	0000C6813	136	113,146	1
	000024456	3,819	44,589	1
	000024488	4,424	45,564	1
	000024520	34,649	29,960	1
	000024527	10,827	37,378	1
	000024579	1,739	25,900	1
	000024614	4,913	33,759	1
	000024634	34,982	65,327	1
	000024684	1,192	28,395	1
	000024697	3,067	44,737	1
	000024784	1,332	46,412	1
	000024796	3,126	45,503	1
	000024832	3,634	53,047	1
	000024839	360	37,553	1
	000024859	19,298	25,885	1
	000024950	132	54,874	1
	000024990	134	85,945	1
	000025182	43,755	27,882	1
	000025232	248	71,802	1
	000025235	371	81,842	1
	000025325	259	65,605	1
	000025440	1,510	32,280	1
	000025518	91	27,680	1
	000025551	1,098	121,025	1
	000025989	8,540	115,752	1
	000026021	2,792	27,490	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	000026146	\$33,797	\$25,925	1
	000026256	180	44,045	1
	000026285	22,860	26,598	1
	000035838	637	71,850	1
	000035868	9,637	46,492	1
	000036109	13,563	25,502	1
	000036178	2,801	29,101	1
	000036259	3,002	25,609	1
	000036283	848	84,799	1
	000036519	40,260	27,086	1
	000036537	2,728	59,101	1
	000036557	535	52,245	1
	000036562	1,487	42,604	1
	000036568	2,653	36,547	1
	000036572	8,844	31,774	1
	000036578	1,387	47,395	1
	000036834	422	66,797	1
	000036886	6,065	27,969	1
	000036889	10,201	28,542	1
	000037172	3,460	123,774	1
	000037182	180	52,249	1
	000036893	3,953	50,856	1
	000037053	6,231	26,559	1
	000037192	11,468	62,710	1
	000037194	15,045	40,804	1
	000037246	667	49,630	1
	000037303	811	30,530	1
	000037305	73	41,618	1
	000037328	155	34,062	1
	000037393	1,732	57,055	1
	000026627	3,385	60,574	1
	000026704	126	57,455	1
	000026746	400	25,698	1
	000027170	1,045	64,052	1
	000027501	552	32,779	1
	000027538	788	106,618	1
	000027654	92	57,265	1
	000027745	1,599	49,452	1
	000027751	1,087	33,219	1
	000027963	9,872	28,571	1
	000035019	1,003	78,031	1
	000035023	255	43,236	1
	000035318	373	50,241	1
	000035334	5,122	25,093	1
	000035390	1,096	31,911	1
	000035394	549	39,509	1
	000035457	5,674	35,613	1
	000035605	10,942	40,924	1
	000035696	291	86,757	1
	000035700	7,352	52,376	1
	000035705	1,735	36,919	1
	000035710	110	43,701	1
	000035724	1,295	64,892	1
	000035736	70	29,861	1
	000035739	1,866	26,576	1
	000035740	69	45,983	1
	000035751	8,541	25,108	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	000035766	\$19, 648	\$44, 164	1
	000035826	10, 260	51, 028	1
	000037499	724	43, 756	1
	000037929	14, 371	33, 783	1
	000040243	23, 579	83, 597	1
	000040863	1, 659	46, 289	1
	000042111	271	28, 336	1
	000042570	152	63, 379	1
	000042976	14, 177	35, 494	1
	000043054	20, 035	29, 868	1
	000043108	32	32, 705	1
	000043348	3, 126	48, 048	1
	000043417	10, 660	52, 169	1
	000043651	594	38, 142	1
	000043676	30, 860	30, 641	1
	000043687	424	62, 128	1
	000011490	5, 333	75, 809	1
	000011084	66	53, 200	1
	000044102	19, 676	91, 303	1
	000044150	396	30, 781	1
	000044218	2, 628	47, 177	1
	000044338	8	32, 411	1
	000044415	6, 550	36, 480	1
	000044897	1, 121	119, 611	1
	000047372	1, 342	51, 132	1
	000047976	240	53, 240	1
	000047998	418	51, 350	1
	000048772	35, 781	94, 538	1
	000049558	434	27, 608	1
	000051416	71	25, 655	1
	000053567	18, 974	31, 275	1
	000055703	11	35, 131	1
	000067319	424	59, 235	1
	000081252	7, 877	83, 575	1
	000090104	8	34, 243	1
	000090269	4, 033	25, 150	1
	000090323	62	47, 113	1
	000043588	33, 768	151, 932	1
	000044088	52	62, 292	1
	000016534	7, 660	47, 479	1
	000020698	31, 686	26, 630	1
	000017707	46	76, 265	1
	000016147	36, 677	68, 661	1
	000017689	207	56, 827	1
	000034391	21, 393	54, 493	1
	000015936	16, 392	51, 848	1
	000035789	1, 276	47, 677	1
	000046619	60	47, 113	1
	000006518	6, 503	46, 289	1
	000003973	538	45, 669	1
	000029915	51, 084	43, 616	1
	000035559	60	42, 604	1
	000047569	1, 066	39, 352	1
	000016300	25, 579	38, 100	1
	000003907	683	32, 674	1
	000022277	404	32, 533	1
	000035583	211	30, 212	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	000015924	\$51, 826	\$29, 092	1
	000003759	3, 347	27, 712	1
	000014784	94, 444	27, 608	1
	000043927	721	25, 303	1
	000016595	4, 418	25, 047	1
	000027344	6, 150	25, 052	1
	000003069	941	24, 991	1
	000017645	1, 001	24, 961	1
	7331212RS	4	35, 727	1
	0043197AK	261	23, 578	1
	2351223JS	28, 236	25, 713	1
	2652250JA	4, 740	41, 312	1
	2654444MS	3, 214	26, 263	1
	2722461NE	7, 730	27, 310	1
	2724181JB	10, 665	69, 621	1
	2726881RP	12	25, 184	1
	2733161HS	3, 516	31, 427	1
	2735200CD	368	-----	1
	2735200EH	114	51, 129	1
	2735200ET	714	-----	1
	2735200HH	1, 688	-----	1
	2735200RM	453	-----	1
	2737151DT	426	32, 979	1
	2744321RF	4, 402	30, 534	1
	3262624RG	2, 968	29, 696	1
	3342832MJ	10, 616	43, 290	1
	3349229RF	3, 502	31, 801	1
	3366800EP	8, 309	-----	1
	3366800HZ	7, 420	27, 092	1
	3467277LM	33	26, 132	1
	3661606AH	12, 836	36, 883	1
	3868854ES	9, 568	48, 640	1
	3931650JB	1, 052	35, 360	1
	3934640EW	15, 437	25, 153	1
	4375483CF	1, 301	34, 072	1
	4550111JF	704	39, 591	1
	4554171AD	6, 794	25, 382	1
	4554673MB	13, 645	27, 997	1
	4721340JM	1, 691	30, 224	1
	4752844SC	5, 153	55, 767	1
	4755159AP	1, 337	25, 984	1
	4759723SG	7, 255	31, 558	1
	4764663HE	78	25, 634	1
	4780104SK	268	73, 488	1
	4830842WH	7, 279	43, 113	1
	4831413LB	7, 802	28, 131	1
	4832751CR	4, 748	56, 241	1
	4840961AB	7, 030	32, 057	1
	4849121DA	13, 193	37, 236	1
	4849121EF	11, 738	-----	1
	4849121EM	6, 791	-----	1
	4849121GE	13, 431	-----	1
	4849121RR	3, 791	-----	1
	4849121WK	18, 885	-----	1
	4851054SD	16, 774	34, 168	1
	5613344ES	4, 621	28, 178	1
	5617242ND	1, 209	33, 853	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	5630923JA	\$8,306	\$36,489	1
	5633260DM	2,497	25,820	1
	5922300MD	3,464	27,964	1
	6478181JS	14,918	29,131	1
	6979669BN	2,851	49,251	1
	7246131HP	2,596	28,590	1
	7249801FG	878	-----	1
	7249801HW	28	40,797	1
	7249801JC	1,526	-----	1
	7321714GT	5,343	48,782	1
	7323023LM	21,992	26,449	1
	7326767FF	8,292	44,687	1
	7354447AS	21,115	32,907	1
	7355077SM	3,938	26,801	1
	7566545LB	120	36,756	1
	7566545TJ	164	-----	1
	7569941DG	11,154	30,586	1
	7569941RP	4,935	33,826	1
	7640501HD	5,249	25,032	1
	7821650CS	16,194	31,901	1
	7821650JF	23,189	-----	1
	7821650WH	17,110	-----	1
	7821810BM	22,738	31,167	1
	7823300JC	1,239	27,023	1
	7823300WD	2,118	-----	1
	7826070JF	5,085	35,579	1
	7882400DG	12,984	-----	1
	7883070CR	16,507	46,181	1
	7883480MG	590	32,204	1
	7884360AH	8,406	33,691	1
	7884360FR	8,061	33,691	1
	7884360HT	8,954	-----	1
	7884360LH	7,820	-----	1
	7886411GC	3,044	27,694	1
	7886411MB	518	-----	1
	M0210	1,877	26,849	1
	00189	2,811	26,427	1
	00304	240	32,085	1
	00319	17,615	25,184	1
	00577	3,581	25,831	1
	01212	690	50,469	1
	01217	696	30,230	1
	01523	1,118	25,847	1
	01703	1,981	25,400	1
	02123	60	32,963	1
	03027	17,144	38,954	2
	03159	18,806	-----	2
	03186	28	28,342	1
	07060	2,866	29,846	1
	10513	22,880	30,771	1
	11129	1,447	43,821	1
	11238	11,038	26,700	1
	11534	12,974	29,357	1
	11960	1,616	29,889	1
	12470	5,644	25,845	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
NEW YORK—Continued	13028	\$5, 188	\$41, 750	1
	13086	962	-----	2
	14297	770	-----	2
	13160	661	33, 566	2
	17030	1, 679	33, 092	1
	010092688	52	26, 683	1
	010034182	25	39, 367	1
	010049197	8	33, 601	1
	010045326	10	39, 633	1
	010093165	14	51, 983	1
	010041175	40	35, 553	1
	010030447	302	26, 639	1
	010077767	640	29, 831	1
	015045783	188	26, 903	1
	010019813	105	56, 407	1
	010025753	229	28, 401	1
	010026097	84	40, 536	1
	010024937	686	34, 337	1
OHIO	001001219	1, 151	92, 945	1
	001002372	92	28, 874	1
	001008985	106	27, 903	1
	001021682	7, 097	26, 921	1
	001021705	652	25, 499	1
OKLAHOMA	100361002	12, 047	55, 965	1
	390130003	19, 881	25, 075	1
	390128003	4, 285	26, 122	1
	100358003	15, 181	28, 616	1
	390152004	17, 256	30, 257	2
	200259011	8, 225	52, 383	1
	169155044	23, 172	25, 804	1
	289463060	24, 747	34, 441	1
	289445074	16, 642	42, 219	1
	390144004	22, 857	30, 542	1
	390150010	20, 810	25, 895	1
	289366010	34, 146	58, 832	1
	289435108	29, 313	39, 372	1
	289432063	23, 523	29, 260	1
	390155028	14, 997	39, 320	1
	289345029	6, 745	30, 021	1
	480230012	15, 338	32, 483	1
	189152032	15, 696	32, 010	1
	390148015	37, 123	50, 084	1
	390154023	37, 208	68, 670	1
	470735011	12, 518	28, 702	1
	289363031	7, 483	37, 328	1
	650647003	19, 899	44, 066	1
	120524014	10, 859	30, 505	1
	390150028	7, 061	28, 257	1
	260445040	8, 665	40, 392	2
	289365032	12, 640	35, 920	1
	189133025	25, 771	26, 190	1
	390160033	12, 908	76, 565	1
	289359060	14, 594	26, 962	1
	390153033	10, 961	28, 339	1
	390148027	19, 302	31, 447	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID IN 1968 ¹—Continued

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
OKLAHOMA—Continued	051234033	\$18,741	\$25,017	1
	351532016	5,730	40,171	1
	390140020	20,669	36,597	1
	390158047	16,855	29,877	1
	390155067	19,948	53,829	1
	390155070	22,102	35,424	1
	289361125	13,489	25,704	1
	289361026	5,897	28,442	1
	289433061	11,684	41,110	1
	390156050	30,406	40,213	1
	390146048	9,430	53,828	2
	390140030	36,497	36,782	1
	289344015	9,709	31,289	1
	470741030	5,569	25,365	1
	480256103	12,399	43,148	1
	289350036	17,425	35,366	1
	100360051	8,763	79,978	1
	040163053	17,237	25,808	1
	390154061	15,175	25,316	1
	390135043	13,681	25,195	1
	390156068	16,885	28,718	1
	470754050	4,783	55,803	1
	051239080	18,299	28,771	1
	289461216	15,093	26,723	1
	160131087	1,680	100,623	1
	390134038	25,348	31,935	1
	390160072	23,811	62,676	1
	240156131	1,740	27,726	2
	100353054	1,023	25,909	1
	289366069	19,525	37,454	1
	390157084	33,141	50,556	1
	289366065	19,628	32,387	1
	470656200	26,462	37,687	1
	LBBMH	3,643	38,812	1
OREGON	000015103	830	12,724	1
	000014067	8,800	15,609	1
PENNSYLVANIA	000041266	5,339	30,416	1
	000041463	932	14,363	1
	000041683	504	12,735	1
	000041685	10,163	17,730	1
	000041682	27,644	19,775	1
	000012740	6,770	13,799	1
	000041672	34,263	19,524	1
	000016988	864	18,578	1
	000041609	6,694	13,988	1
	000040030	68,478	14,993	1
	000040757	19,833	18,022	1
	000040759	2,444	16,939	1
	000001032	71,240	14,477	1
RHODE ISLAND	000000355	2,667	30,129	1
	000000484	7,798	31,083	1
TEXAS	000001276	1,334	28,802	1
	00001445	27,778	30,560	1
	0000E562	25,447	30,374	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
TEXAS—Continued	0000A288	\$17, 069	\$29, 761	1
	00001250	12, 338	28, 539	1
	0000F127	13, 926	28, 270	1
	00009822	51, 319	27, 362	1
	00005404	43, 501	27, 127	1
	0000A902	52, 098	26, 555	1
	0000C227	1, 086	26, 235	1
	00002565	18, 027	25, 260	1
	0000C307	1, 315, 676	94, 111	2
	0000C550	201, 976	54, 748	2
	0000E151	236, 215	47, 720	2
	0000C407	186, 074	41, 263	2
	0000F327	351, 542	31, 552	2
	0000F437	31, 424	29, 777	2
	0000C399	248, 929	29, 226	2
	0000C556	125, 997	27, 758	2
	0000E697	74, 609	26, 837	2
	0000C320	123, 551	26, 791	2
	0000E684	37, 650	25, 688	2
	00000591	910	57, 403	2
	0000E424	2, 174	52, 213	2
	0000H100	6, 275	42, 954	2
	0000E513	18, 945	42, 466	2
	00003535	308, 769	39, 898	2
	0000F853	19, 923	37, 339	2
	0000H747	230, 144	31, 501	2
	0000H900	19, 360	29, 962	2
	0000H852	181, 226	28, 027	2
	00000077	29, 420	27, 983	2
	0000F268	4, 307	27, 320	2
	00009568	86	26, 806	2
	0000A646	56, 309	25, 808	2
	0000B649	46, 183	54, 316	1
	00009536	63, 664	43, 552	1
	00001342	97, 401	52, 762	1
	00004660	95, 574	37, 523	1
	00008873	67, 627	37, 199	1
	00008357	33, 507	35, 442	1
	00002024	36, 028	35, 115	1
	0000F024	21, 959	35, 012	1
	0000A413	13, 522	30, 605	1
WASHINGTON	30005501	6, 709	29, 714	1
	30303501	2, 470	25, 728	1
	20007501	203	35, 640	1
	206509	2, 160	25, 911	1
	203054	1, 253	25, 846	1
WEST VIRGINIA	000008676	97	26, 609	1
	000000468	18, 233	27, 205	1
	000005127	1, 086	32, 359	1
	000006694	7, 935	25, 378	1
	000007061	14, 200	47, 486	1
	000007430	1, 009	29, 434	1
	000008162	8, 892	47, 133	1
	000008647	6, 434	66, 501	1
	000000476	12, 599	39, 567	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

**APPENDIX B.—TOTAL MEDICARE-MEDICAID PAYMENTS
TO PHYSICIANS PAID \$25,000 OR MORE UNDER MEDICAID
IN 1968 ¹—Continued**

State	Identification number of practitioner(s)	Medicare payments	Medicaid payments	Type of practice ²
WISCONSIN	000101134	\$11,080	\$31,290	1
	000101547	28,912	45,504	1
	000102145	9,932	53,324	1
	000102903	29,616	87,684	1
	001102543	3,578	29,916	1
	001602548	82	52,228	1
	002502521	68,039	45,859	1
	007002999	172,996	239,554	2
	007001904	16,336	57,265	2
	007001684	27,408	31,029	2
	15869	314	30,641	1
	20111	14,797	25,126	1
	34167	10,705	36,204	1
	41011	21,750	31,572	1
	51014	20,121	31,480	1
	52113	2,997	26,933	1
	68275	30,484	25,101	1

¹ Excludes those physicians paid \$25,000 or more by medicaid who did not also receive medicare payment.

² 1—solo practitioner; 2—group or clinic; 3—hospital-based.

APPENDIX C

Summary of Medicaid State Audits by HEW Audit Agency

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APPENDIX C.—SUMMARY OF MEDICAID STATE AUDITS BY H.E.W. AUDIT AGENCY



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

WASHINGTON, D.C. 20201

AUDIT AGENCY

AUG 26 1969

Miss Mary E. Switzer
Administrator, Social and
Rehabilitation Service
Department of Health, Education,
and Welfare
Washington, D.C. 20201

Dear Miss Switzer:

The enclosed report summarizes the principal problem areas noted in our audits of grants to 16 selected States participating in the Medical Assistance Program (Medicaid) and our review of the administration of the program by the Social and Rehabilitation Service (SRS). Copies of the individual reports citing weaknesses noted in each State audit were previously transmitted to operating officials in your agency. Although no prior reports have been issued regarding SRS's administration of the program, our findings were discussed with various SRS officials and a draft copy of this report was previously furnished.

The report shows the existence of widespread administrative problems which require prompt action by both the States and SRS if program objectives are to be achieved efficiently and economically. Problem areas of most concern centered on: (1) duplicate payments, excessive rates and fees, and other types of erroneous charges which would not have occurred if adequate management control had been established over claims submitted; (2) the lack of systematic reviews of utilization of service; and (3) the need for improved procedures in determining eligibility and operating Quality Control programs. In separate reports to each State we recommended steps that should be taken to correct these weaknesses and improve State administration of the program.

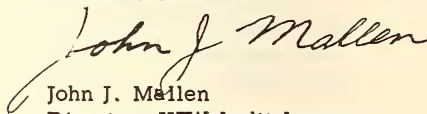
Insofar as SRS regional and headquarters operation of the program is concerned, recommendations included in this report call for a current reexamination of resources utilization and capability with a view toward

staff expansion and strengthened administrative controls (to some extent this has already been acted on). Also recommended are improvements with regard to (1) lack of effective followup on deficiencies disclosed by Program Review and Evaluation Projects; (2) untimely issuances of guidelines needed to clarify the requirements of amendments to the Act; and (3) the need for a more clearly defined mission and responsibility of the field administration.

We would appreciate advice as to action taken on these recommendations.

We hope that this report will be of help to you in administering the Medicaid program, and we will provide any additional information you may need. Copies of this report are being sent to the Secretary and other top Department officials.

Sincerely yours,



John J. Mallen
Director, HEW Audit Agency

Enclosure

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REPORT ON
REVIEW OF SELECTED AUDIT AREAS
GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

SOCIAL AND REHABILITATION SERVICE

I - SUMMARY

In providing medical care to needy people in the first 3 years of the Medical Assistance Program (Medicaid), the State and Federal Governments spent over \$7.5 billion. Our reviews in the 16 States that spent over 85 percent of this money showed the existence of widespread administrative problems which require prompt action to achieve program objectives efficiently and economically and to retain public confidence.

Although conditions varied by States, in general we found:

1. Many instances of duplicate payments, excessive rates and fees, and other types of erroneous charges would not have occurred if adequate management controls had been established by the States, or their fiscal agents, over claims submitted by hospitals, nursing homes, physicians, pharmacists, and dentists.

2. Systematic reviews of utilization of services provided to program recipients were not being made. Instances were noted of excessive prescription drug refills and other overutilization of services. Unless the required utilization reviews are effectively carried out, there will not be adequate assurance that such instances are not in reality widespread.

3. Improvements are needed in the important function of determining the eligibility of individuals for medical assistance. Upon the reliability of these determinations rests huge amounts of public expenditures.

The significance of the overall problem is shown by conservative estimates that questionable payments made in the program's first 3 years probably averaged more than \$100 million a year. However, inherent procedural weaknesses in eligibility determinations and vendor payments precluded an analysis of the full scope of the errors, and we therefore cannot say what the full amount is.

In Part III of this report, we discuss, within broad categories, major problem areas, and summarize conditions found in the various States.

Because of differences in size, local conditions, and managerial emphasis, States implemented the overall program in various ways. But underlying patterns of performance lend themselves to comparable analyses and point the way toward useful remedial action.

What are these basic patterns, and what should be done about them? It seems clear that the States and SRS did not ensure that appropriate managerial systems were adequately implemented when State plans were approved and first put into operation. Nor did we see timely evaluation of program operations, afterwards. Generally, we found a need for advance planning, comprehensive guidelines, adequate mechanization for the large volume of transactions, and a system for profile analysis of the individual recipients and medical vendors.

The necessity for administering the Medicaid program in States with large caseloads requires concerted advance planning and the establishment and maintenance of administratively sound managerial controls - if abuses, errors, and inequities are to be avoided. Also a manually controlled, or decentralized, disbursement system for assistance payments is not administratively feasible with the advent of the Medicaid program. It is almost impossible to control a vast number of transactions without provision for controlled, automated input and periodic evaluations. The Medicaid program was initiated, and continues to be operated in many States, without some or all of these basic safeguards.

What can be done to remedy the situation? First, adequate mechanization, and related operation resources, are essential. These would enable the States to record, on a timely basis, a large volume of daily transactions and thereby provide a viable base for reliable eligibility determinations, vendor payments, and utilization reviews. This need should be met as soon as possible.

Secondly, specific recommendations presented in our reports on individual States' operations should be implemented. For the most part these recommendations contained remedial suggestions which can be accomplished by State action. Our recommendations generally focused on needed improvements in procedures, controls, reviews, analyses, and reports, and these are presented in some detail in Part III of this report.

Last, and equally important, SRS should participate more actively as coordinator and consultant in the managerial aspects of the States' programs to help prevent problem areas from developing. Where problems have developed, measures should be employed to correct the situation. Powerful and closely coordinated efforts are needed to overcome existing problems and prevent new ones from developing. In Part IV of the report we

summarize the findings made in our review of SRS's administration of the program, and make certain recommendations. Principally, we are recommending that SRS: improve its followup on deficiencies found in State operations by various review teams; complete the issuance of needed guidelines to clarify requirements of the Social Security Act; and reexamine and more clearly define the mission, responsibility, and resource capabilities of its personnel in relation to the overall managerial requirements.

II - BACKGROUND AND SCOPE

This report summarizes the principal problem areas noted in our audits of State agencies and fiscal intermediaries participating in the Medical Assistance Program and in our review of the Social and Rehabilitation Service's administration of the program.

Medicaid is a Federal-State program that provides medical care to low-income people. Grants to States were authorized by Title XIX of the Social Security Act, which became effective on January 1, 1966. Title XIX established a single and separate program which makes medical care available to needy and medically needy individuals who are (1) under the age of 21, (2) the needy parent or relative with whom an eligible child is living, (3) 65 years of age or older, (4) blind, or (5) 18 years of age or older and permanently and totally disabled.

Title XIX replaces the provisions for medical care for the needy in Title I, Old-Age Assistance and Medical Assistance for the Aged; Title IV, Aid and Services to Needy Families with Children; Title X, Aid to the Blind; Title XIV, Aid to the Permanently and Totally Disabled; and the consolidated program, Title XVI, Aid to the Aged, Blind, or Disabled. Title XIX also supplements the basic health insurance plans administered through the Social Security Administration under Title XVIII of the Social Security Act.

Medicaid is optional with the States until 1970. Until then, States may continue to provide medical care under Titles I, IV, X, XIV, and XVI. However, beginning January 1, 1970, or on such earlier date as the State elects to adopt a medical assistance program under Title XIX, no Federal matching funds for medical care of the needy will be available through other assistance programs. States wishing to establish a medical assistance program under Title XIX will need to submit to HEW a new and separate State plan for approval by the Medical Services Administration, Social and Rehabilitation Service. By 1975, all needy and medically needy who meet State eligibility standards are to have comprehensive care and services available through this program.

The Federal share of the cost varies among States according to per capita income, from a low of 50 to a high of 83 percent. There is no ceiling on the amount of Federal reimbursement. Federal funds are also available to pay 75 percent of the cost of salaries or training of skilled medical personnel, and staff directly supporting such personnel, of the State agency or any other public agency administering the State plan. The Federal share of other costs of State and local administration is 50 percent.

Of the \$7.5 billion spent on Medicaid during calendar years 1966-67-68, the States spent \$3.8 billion and the Federal Government \$3.7 billion. As of December 31, 1968, there were 42 jurisdictions participating in the program, and by July 31, 1969, there were 44.

The findings discussed in this report are based on audits of 16 States and the Medical Services Staff of SRS in 6 regions and Departmental Headquarters. These 16 States received grants of more than \$3.1 billion, 85 percent of the \$3.7 billion Federal share. The States audited and the amounts of Federal funds expended by each are shown in Exhibit A.

Audits made in the States consisted principally of a review of the policies and procedures used to administer the following selected areas of the Medicaid program: (1) adherence to eligibility criteria and quality control of medical eligibility case actions, (2) establishment of costs for medical care and services, and (3) payments for medical assistance. The primary objective of our review was to determine whether controls were adequate to assure that expenditures of Federal funds were reasonable and complied with applicable laws, regulations, and SRS guidelines. Summary results from a limited review of nursing home activities in two States are also included in this report.

We reviewed the operations of the Medical Services Staff to determine how they met their responsibilities under the Medical Assistance Program and whether they provided adequate guidance, assistance, and review of the operations of the State agencies which administer the program.

III - DETAILS OF FINDINGS AT STATE AGENCIES

MANAGEMENT CONTROLS

Decisions made by management in the Medicaid program have a substantial impact on welfare recipients, medical providers, legislative bodies, and the taxpaying public because of the large amount of public funds expended in the program. It is important, therefore, that management be provided with the proper tools to carry out its assigned responsibilities in an effective and efficient manner consistent with program objectives. The degree to which management is currently informed about all aspects of the operation determines in a large measure its capability to make decisions in the best interest of the program. Management, therefore, is responsible for establishing the necessary procedures, controls, and reporting systems which will provide the information required to make informed judgments.

A well designed system of management control assures efficiency, economy, and adherence to programed performance. Such a system includes providing carefully devised and frequently updated standards of comparison in accordance with which activities are designed and carried on, and against which their output can be measured.

The essence of this control is the action which adjusts operations to conform to prescribed or desired standards or requirements. Management needs timely and adequate information on performance, the source of which may be direct observation; routine and periodic operating, accounting, statistical, and analytical reports; audits; and functional staff reviews.

Our review of the Medicaid program shows that in a significant number of States these principles were not followed and basic needs were not met. Weaknesses in overall administration were generally caused by inadequacies in procedures, internal controls, and supervision and review. Examples of these weaknesses follow.

California - The State permitted nursing homes which had not met Federal standards of care to participate in the Medi-Cal program. Eighty-seven nursing homes were allowed to participate after July 1, 1968, even though by that date they had not submitted the required plans for meeting Federal standards. Since January 1, 1969, at least 225 homes have been allowed to participate in the program without actually meeting the standards. This situation occurred because the California Department of Health Care Services did not take timely action to require nursing homes to correct deficiencies or remove them from the program. As a result, Medi-Cal patients in these particular nursing homes have not had the quality of care to which they were entitled under Title XIX.

During the period July 1 through December 31, 1968, the 87 homes were paid \$380,000 for which the State claimed Federal participation. We believe that the State is not entitled to this participation and have recommended that it refund the Federal share - \$190,000. We

also recommended that the State refrain from claiming Federal participation in payments to nursing homes that did not meet Federal standards after January 1, 1969, and decertify those homes not currently meeting the standards.

Illinois - The Department of Public Aid (IDPA) did not comply with the provisions of the Social Security Act in that it did not determine whether average quarterly expenditures for mental health services from State, local, and Federal sources during the period January 1, 1967, through June 30, 1968, exceeded the quarterly average of such expenditures from such sources for the fiscal year ended June 30, 1965. Expenditures in each quarter in excess of the 1965 quarterly average are subject to Federal participation if such excess expenditures are for medical services to patients 65 years or older in a mental institution. There was no assurance, therefore, that the IDPA maintained its required level of effort for the period and that the total amount claimed for individuals 65 years or older in mental institutions was eligible for Federal participation.

IDPA officials advised us that the State had not made a determination regarding maintenance of level of effort for mental health services. However, the State later presented a prepared schedule of annual operating disbursements for fiscal years 1965 through 1968. We did not consider this sufficiently supportive because the expenditures were not determined on an average quarterly basis, nor were there assurances that the figures were consonant with official expenditure records.

We recommended that the IDPA make the required determination with respect to maintenance of effort and that a refund be made to the Federal Government for the amounts claimed in any quarter in which the Federal requirement was not met.

Nebraska - Some mental patients whose care was charged to the Title XIX medical assistance program were placed in State operated facilities which did not meet HEW certification standards for mental institutions. Charges to the Medicaid program for mental patients in institutions totaled almost \$2 million in fiscal years 1967 and 1968, the Federal share of which was about \$1.2 million. However, no controls and procedures had been established to assure that the patients received the care intended by the program. Some expenditures were ineligible charges to the Medicaid program; others will require further information from the State agency before a determination can be made (Nebraska was not one of the States selected for audit. This deficiency came to our attention during our regular review of Public Assistance.)

Washington - Under the State plan, hospitals are reimbursed for actual costs of providing Title XIX services. An institution receives interim payments at rates expected to approximate actual costs, but within 90 days after the close of its fiscal year the hospital must compute actual costs and submit a report to the State for audit so that final settlement can be made. As of January 1, 1969, only 18 of 115 participating hospitals had submitted cost reports and only 1 of 18 reports was filed on time. The 97 hospitals which had submitted no reports were about 8 months late. The State agency did not know when reports for the hospitals were due and had not asked any hospitals why the reports had not been submitted. Because of this laxity on the part of both the hospitals and the State, as of April 2, 1969, no final settlement had been made.

Our review in Washington also disclosed that additional medical coverage could be provided to children who are eligible under both the Title XIX program and the Crippled Children's Services (CCS) program through better coordination between the respective offices responsible for their administration. During fiscal year 1968 the Washington Department of Health, the CCS unit, did not provide many of the needed services to eligible children due to inadequate funds. As a result, medical care for these children was unnecessarily delayed or in some cases not provided at all because the children were not referred to the State Department of Public Assistance by CCS. Improved coordination between the two agencies administering these programs could result in more needy crippled children receiving adequate medical care.

Wisconsin - During the period July 1, 1967 to April 30, 1968, inpatient hospital payments were based on normal charges; those made after April 30 represented estimated costs. No procedures were implemented for subsequently adjusting the normal charges and the State agency did not provide guidance to its fiscal agents for preparing the cost report or for making retroactive adjustments when estimated costs were found to be inaccurate. Procedures for examining cost statements were also inadequate. In some instances, unaudited statements were accepted without examination.

Missouri - The State agency received about 1.1 million physicians' billings, totaling about \$7.1 million, for the 15-month period ended December 31, 1968, but had not implemented procedures to compile these billings into history files for each participating physician. Accordingly, the agency had not reviewed physicians' charges to ascertain that individual fees adhered to a uniform charge for each type of medical procedure billed for and were usual, customary, and

reasonable charges. Furthermore, there was no documentary evidence to support the fee schedule established by the State agency.

New York - New York City made an error in computing its municipal hospital per diem rate so Federal reimbursement for the city's fiscal year 1967 Medicaid operations was about \$234,000 too high. In computing the rate, the city included as an item of expense \$694,000 of costs for Department of Hospitals investigatory personnel. The Department of Hospitals, however, had previously been reimbursed for these costs by the city's Department of Social Services. We recommended that the State either refund the \$234,000 or reduce future claims for reimbursement by this amount.

California - States are authorized to use Medicaid funds to make payments for premiums, commonly referred to as the "buy-in," to the Social Security Administration for Supplemental Medical Insurance Benefits (SMIB) under Medicare. The State agencies are responsible for assuring that all eligible persons are provided coverage under SMIB and that the benefits are utilized.

The State's records of persons eligible to have their Medicare premiums paid for by Medicaid (buy-in beneficiaries) did not provide accurate or timely information. As a result, claims payable by Medicare have been paid by Medicaid. A State study of payments made from August through December 1967 showed that \$647,000 in claims chargeable to Title XVIII were paid with Title XIX funds. The State agency did not consider that this period was unique, so we recommended that it extend the review of claims to periods prior to and following the 5-month period and recover from Medicare any improper payments.

The existence of various sources of direct input to the State agency and SSA eligibility files has caused a significant difference between these files and has not provided assurance that either file is complete. The State agency recently reported for the month of August 1968 that its eligibility file contained 246,000 identified buy-in beneficiaries while SSA reported 280,000 beneficiaries on its records. However, the State agency has estimated that 320,000 persons are eligible for buy-in benefits and should be included in the buy-in eligibility files. Consequently, there is no complete eligibility record containing the information necessary for timely and accurate claims processing and accurate determination of the premium liability.

In May 1968, SSA provided the State agency with magnetic tapes of its eligibility file for the purpose of identifying and resolving the

differences. The State agency did not have the computer programs necessary to utilize the tapes and had not developed the necessary programs at the time of our review. The agency had set several dates for initial reconciliation to be made and to establish procedures for a continuing reconciliation, but none of these dates had been met because of the low priority assigned to the buy-in and a lack of personnel capable of preparing the necessary computer programs. We believe that the State agency should provide the necessary resources to complete a reconciliation as soon as possible.

Estimates by the State agency of persons eligible for the buy-in compared to the number of persons being bought-in, indicate that California is making insufficient payments to Title XVIII. The buy-in agreement with the Secretary of HEW provides that all eligible persons will be provided SMIB when they become eligible, and the Title XIX program will pay the cost of the premiums. Currently, an estimated 40,000 eligible persons have not been identified and reported to SSA, resulting in an understatement of the premium liability on monthly invoices from SSA of about \$160,000.

New York - The State Department of Social Services did not make adequate audits of Medicaid operations at local agencies. During the period May 1, 1966, to December 31, 1968, only 31 audits were started, of which only 16 were completed, at the 64 local agencies in New York State. In the New York City area, only three audits had been started, and none completed, since the inception of the program. Moreover, in our opinion, the audits that were performed were not effective because: (a) causes of deficiencies found were not shown, thereby inhibiting corrective action, (b) findings disclosed in one part of the State were not transmitted to other audit sites to ensure appropriate statewide audit emphasis, (c) only 1 month's transactions were used as the basis for the audit tests and deficiencies found in that month were not examined in other months to determine overall impact and trends, and (d) corrective action was generally required only for that month in which the test was made and errors found. All these represent serious weaknesses in management controls.

We recommended that greater emphasis be placed on an audit program with appropriate supervision and monitoring to ensure adequate coverage. We further recommended that SRS followup with the State agency to ensure that an effective audit program exists and is operating properly.

The New York City Department of Social Services (NYCDSS) does not have an internal review section which can review, evaluate, and appraise the Medicaid operation of the department on a regularly

programed and systematic basis. Moreover, within the Bureau of Medical Assistance, no organizational element has been designated to perform these functions. The need for this important management tool is emphasized by the significant weaknesses we found during our audit of the administration of the Medicaid program. For example, even after audits by the City Comptroller disclosed that voluntary hospitals had overcharged the city \$1.5 million in 2 years, NYCDSS failed to credit this amount to the Medicaid program.

These conditions, when considered together with the continuing legislative changes in the program and the complexity and size of the Medicaid operations in terms of employees, money, and facilities, point up the need for top management to have a control to assure itself that established plans, policies, and procedures are being implemented and executed efficiently and effectively. We reported on this lack of managerial control in our prior audit of public assistance administration. While we were advised that favorable consideration was being given to our recommendation, to date no effective action has been taken to implement our suggestion.

We recommended that NYCDSS set up an internal review section independent of operational segments of the Department and responsible directly to the Commissioner.

Rhode Island - The State's Medicaid manual allows refilling of prescriptions up to 90 days after the date the original prescription was filled. We examined the records on 900 prescription refills and found that 120 were refilled from 1 to 305 days after the 90-day limit expired. The State manual also limits refills to three per prescription. We found 10 cases where a fourth refill was made, although in each case the refill form showed that three refills had previously been made.

Pennsylvania - Weaknesses in administration of Medicaid in the State Welfare Agency were generally attributed to (a) failure to comply with prescribed procedures, (b) poor internal controls, and (c) lack of effective supervision and review. There was reason to believe that top management was not always aware of these conditions. We recommended that the State agency establish an internal review section to determine that its policies and procedures are accomplishing their objectives, and to evaluate the effectiveness of administration. There should be a regularly programed procedure for periodic reviews, evaluations, and appraisals of all ongoing operations of the agency. This could result in (a) a more timely remedial action, (b) improved safeguards and stronger administration, and (c) significant reductions in program costs to the State and Federal Governments. To be more effective, we believe that the internal review unit should be directly responsible to the Secretary of Public Welfare or his deputy.

Texas - Our review disclosed a need to strengthen the State Department of Public Welfare (TSDPW) procedures for certifying and authorizing nursing home care for eligible individuals. After TSDPW's Division of Medical Services certifies individuals as eligible for nursing home care, the certificate of eligibility is forwarded to caseworkers in the field, who authorize the nursing home care and forward the authorization to TSDPW's Division of Data Processing, which is responsible for processing the authorizations. There were no controls, however, to ensure that nursing home care was authorized only for those who were certified. Conversely, there was no control to ensure that caseworkers always authorized nursing home care for those individuals certified as eligible.

We recommended that TSDPW strengthen its internal control procedures by providing a cross-reference system between the Divisions of Medical Services and Data Processing on all recipients certified and authorized for nursing home care.

Michigan - Unissued Medical Assistance Authorization (ID) Cards were not prenumbered, no control register was maintained, and blank cards were not adequately safeguarded. The ID card is the only identification and authorization required for the holder to obtain physicians' services, prescription drugs, and certain emergency outpatient hospital services. No one employee was designated by the State agency as the responsible official for the control and issuance of these cards. We noted that several employees had a supply of blank unnumbered cards which were not locked up.

Under these conditions it is possible for unauthorized persons to obtain ID cards and obtain certain medical services without the State agency being aware that an ID card is missing. We recommended that controls over storage and issue of the ID cards be strengthened.

Forms used to open, change, or close all Public Assistance (Group I) and Medically Needy (Group II) cases were forwarded daily to the State agency by the county welfare agencies. Those pertaining to Group I cases were recorded in a document control register and reconciled to the public assistance payments listing. Forms applicable to the medically needy cases, however, were put into the State agency's system without being recorded on a document control register or any other similar record. It is possible, therefore, for unauthorized Group II cases to be placed into the system, and for lost cases to be temporarily undetected. We recommended that Group II documents also be subject to control similar to the Group I cases.

New Mexico - Our examination disclosed management weaknesses in administering the program which, in our opinion, have hindered the maximum utilization of resources in accomplishing program objectives. Examples of deficiencies noted were: (a) some functions of program administration were spread throughout the agency and not located as a cohesive unit in the administrative structure of the agency, (b) the agency had not established procedures to build up a qualified staff as required by Federal regulations, and (c) the agency did not have an effectively functioning medical advisory committee as required by Federal regulations.

In 12 States we found that the agencies responsible for Medicaid did not make systematic utilization reviews of services provided to recipients, either because the necessary data was not available or because the agencies did not use data that was available. Without such management reviews of program expenditures, neither the State nor SRS can be assured that there are not abuses in the Medicaid program resulting from (a) overutilization of services by recipients, (b) overservicing by medical providers, (c) duplicate payments, (d) fraudulent claims, and (e) other undesirable practices.

Section 1902(a)(30) of the Social Security Act, effective April 1, 1968, requires that, "A State plan for medical assistance must provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." The SRS regulations implementing this section of the Act provided that, "Effective April 1, 1968, a State Plan for medical assistance must: a. Provide that a process(es) of utilization review is established for each item of care or service . . . that is included in the State's medical assistance program." Our audits showed, however, that only 4 of 16 States made systematic reviews.

California - Significant numbers of Medicaid recipients in skilled nursing homes - as many as 35 percent in one county - did not require this level of care. In addition to Section 1902(a)(30), the State's regulations stipulated that no services shall be covered which are not reasonable and necessary for the prevention, diagnosis, or treatment of disease, illness, or injury. Thus, only recipients with medical problems requiring skilled nursing home care should receive such care under Medi-Cal, California's Medicaid program. Medi-Cal does not provide for lesser levels of care, such as those

for boarding homes or intermediate care facilities. Such care, if available, is to be provided under the categorical aid programs.

Studies of nursing home utilization made by Santa Clara and San Diego counties showed that from 22 to 35 percent of the recipients in skilled nursing homes did not require skilled nursing care. If these studies are representative of nursing home utilization throughout the State, the excess cost to the program because of overutilization could be as much as \$33 million annually.

Representatives of the Department of Public Health and Alameda and Santa Clara County Medicaid consultants said that the State was fully aware of the problem of overutilization, or inappropriate utilization, of skilled nursing homes. They also said that persons not requiring skilled nursing care are placed in nursing homes under the Medi-Cal program primarily because facilities providing lesser levels of care, which would be more appropriate, are not available in sufficient numbers in the State.

The State agency is in the process of establishing regional and district offices throughout the State. Upon completion of this decentralization, the program consultants will be directly responsible to the State agency instead of to the various counties. The State agency therefore expects the reviews for placement of patients in nursing homes to be applied on a more uniform basis than in the past. Medical-Social Review Teams are expected to be established eventually to evaluate the placement of recipients from both a medical and social point of view. The State agency believes that improved screening by these review teams will significantly reduce improper utilization of skilled nursing homes. We found, however, that with the exception of guidelines limiting skilled nursing care to those persons needing such care, no other specific plans, policies, or guidelines for the elimination of nursing home overutilization had been formulated.

We recommended that the State agency take action to assure that Federal funds are not claimed for skilled nursing home services provided to persons not requiring such services, that Medi-Cal program consultants be instructed not to approve such care for individuals not requiring it, and that a utilization review program be established for nursing homes participating in Medi-Cal.

New York - The New York City Department of Social Services had no recipient or vendor history profiles which could provide a basis for control over expenditures. The NYCDSS computer was not effectively used to provide management with information on payments

made on behalf of recipients so that an effective review and evaluation of medical services rendered under the program could be made. For example, the computer could not be used to determine the cost of services rendered to Medicaid recipients. Lack of computer capability in this area alone resulted in the inability of NYCDSS to (a) recover the values of services rendered to ineligible recipients, (b) effectively pursue its procedure for processing fraud cases, (c) determine when proper collections should have been made from recipients with "excess income," and (d) detect duplicate payments made to vendors.

Wisconsin - The State agency did not have a systematic plan for making utilization reviews of benefit payments. Payments reviewed were either selected arbitrarily or were referred by a fiscal agent. Under this procedure each payment does not have the same chance of being reviewed, so the results may be biased. Furthermore, reviews made by two fiscal agents were limited to those payments for which the documentation was readily accessible. State agency officials said that the excessive time involved in locating the various documents precluded a more complete and adequate test. Comprehensive reviews, therefore, were not made. This procedure is inadequate because it will not disclose (a) overutilization of services, (b) unusual trends in services to recipients, or (c) duplicate payments. State agency officials stated that these reviews were also limited because the fiscal agents did not maintain profiles detailing services provided to recipients.

Washington - The recent adoption of the declaration system resulted in a significant reduction of visits to nursing homes for eligibility verification purposes. Placement workers were reassigned to desk reviews of financial declarations of State Department of Public Assistance (WSDPA) applicants and recipients. This absence of on-site visits has weakened management controls.

Our visits to several nursing homes disclosed that on-site reviews should be resumed and expanded to include reviews of areas other than the personal funds of WSDPA patient-residents. Presented below is a summary of the results of our review of drug records and drug purchase procedures.

Drug Records - We found a need for WSDPA review of patient drug records at each nursing home. Drug orders and receipts had not always been recorded in the nursing home records. Without such postings, there is no assurance that drugs charged to WSDPA were actually furnished to the patients. For example, at one nursing home we tested 126 drug transactions for 7 patients and found that 10 different prescriptions paid by WSDPA were not recorded in the patient records.

Drug Purchase Procedures - At one nursing home we found instances where drugs purchased from private pharmacies should have been obtained through State sources. WSDPA requires that certain drugs for former patients of State hospitals be obtained from these institutions in order to participate in cost advantages available to the State institutions. The nursing home drug records of four former State institution patients showed seven instances where drugs purchased from private druggists should have been ordered from the State hospitals. Purchases from the State hospitals result in substantial savings.

We recommended that WSDPA resume on-site reviews of nursing homes, including tests of drug records and drug purchase procedures.

We believe that the absence of procedures providing for the maintenance and active review of recipient and medical providers profiles precludes the utilization of an effective internal control method for monitoring expenditures by the State agencies and/or fiscal agents to assure the propriety and correctness of expenditures, the detection of duplicate payments and overpayments, and the detection of potential abuses of the program by medical providers or recipients. Therefore, we feel that unless procedures are established for the maintenance and active review of medical providers and recipient history profiles, the responsible State agency cannot assure SRS that payments of claims made on its behalf are proper under the Medicaid program.

Recommendation

We recommend, therefore, that SRS take steps to assure that the States have adopted utilization review procedures, that the procedures are put into effect, that there is a continuing review and evaluation of the data, and that corrective actions are taken when deficiencies are found.

PROCEDURES FOR PROCESSING CLAIMS

In 13 States we found that adequate procedures had not been established for such aspects of claim processing as preventing, identifying, and recovering duplicate payments and overpayments, and identifying potential third party liability. As a result, substantial amounts of Federal funds which could have been used for other worthy purposes in the Medicaid program were spent unnecessarily.

Good management practices include checks and controls that help to assure maximum efficiency, economy, and adherence to program objectives and requirements. The general objective of adequate control over disbursements

is to provide for proper disbursements in a timely and efficient manner and to prevent improper disbursement of funds.

Our review disclosed, however, many instances of State agencies or fiscal agents maintaining historical profiles for medical providers, yet not verifying claims to these or other records to determine whether a similar claim had already been paid. Some States and fiscal agents had not established any controls to determine whether overpayments had been made, but relied upon medical providers to voluntarily refund any overpayment. In addition, potential third party liability claims in many States were not always identified, either because processing procedures were not followed, were inadequate, or had not even been established. We also found that some payments to medical providers were delayed because of an excessive amount of time required to verify recipient eligibility.

The following illustrate the deficiencies found in our audit of claim processing procedures.

Duplicate Payments and Overpayments

California - Procedures at Blue Cross were inadequate to preclude duplicate payments for medical services provided under the Medicaid program. Duplicate payments resulted from claims coding procedures that effectively bypassed the computerized edit systems, from an unnecessarily large number of conditions that had to be met before machine rejection of duplicate claims, and for other reasons not readily determinable because documentation on computer program changes was not retained. An examination of the Medicaid payment histories for 99 recipients selected at random disclosed that one or more duplicate payments had been made to providers of medical services for 14 of these recipients. A review of current payments disclosed that about 4 percent were duplicated, and multiple payments during a recent 3-month period could amount to as much as \$200,000. Total duplicate payments from March 1, 1966, to February 28, 1969, could be as much as \$2.4 million. We believe that corrective action should be initiated to identify and recover Federal funds improperly claimed as a result of overpayments for medical services.

Pennsylvania - Duplicate payments to physicians, dentists, pharmacists, and other vendors could have been avoided if necessary controls had been established. We conservatively estimated that undetected duplicate payments amounted to more than \$80,000 a month, about \$1 million a year, of which the Federal share was about \$550,000.

New York - The New York City Department of Social Services overpaid dentists because it did not have separate patient history and vendor files and so could not relate duplicate billings to invoices previously received. Our test of payments made over a 5-month period in 1968 showed that more than 10 percent of the dental care received by Medicaid recipients was paid for more than once. During the 11 months ended December 31, 1968, dentists voluntarily refunded about 850 duplicate payments totaling more than \$500,000. This volume of voluntary refunds clearly indicates that total overpayments were substantially higher.

Massachusetts - The State agency did not effectively carry out its responsibility to control processing, reviewing, and paying of vendor claims. Complete written procedures were not issued and local welfare office practices were not monitored. This failure to provide detailed written procedural instructions for processing and reviewing vendor claims contributed significantly to the deficiencies disclosed by our review at the Boston, Springfield, and Attleboro Welfare Service offices. Instructions to operating personnel were not sufficient to preclude duplicate payments, excessive fees paid for example, to doctors and dentists, and payments of excessive drug prices.

We found that the Boston office did not have adequate procedures for checking fees against established schedules. Although employees stated that claims were checked against fee schedules, our review of 131 payments to dentists and physicians disclosed that 11 claims were overpaid. This error rate of 8.5 percent indicates inadequate review.

A high percentage of drug claims we examined was overpriced. In Attleboro, almost 9 percent of the invoices were overstated by about 8 percent of the correct price. In Springfield, over 36 percent of the invoices were overstated by about 5 percent. The Boston office was overcharged an average of 13 percent on almost 50 percent of the drug invoices we examined.

Reviews of drug bills by welfare employees needed improvement. One office reviewed only those bills over \$10, although most prescriptions cost less than that amount. Another office reviewed bills only for arithmetical accuracy and did not check for proper dosage, refills, prices, or eligibility.

A consulting firm hired by the State agency was developing new systems and procedures to process Medicaid vendor claims. When fully operative, these systems and procedures should control the

deficiencies noted in our audit. However, they will not be applied retroactively to determine the extent of ineligible payments made prior to the time the system becomes fully operative. Other review methods will have to be employed for the prior claims.

Third Party Liability

California - Potential third party liability claims were not always identified because processing procedures were not followed or were not adequate. Prior to June 1967, the fiscal agent did not have procedures to identify Medicaid claims for which third parties may have been liable. As a result, collection action was not initiated and the fiscal agent used Medicaid funds to pay claims for which third parties were liable. We also found that claims were processed without determining the beneficiary's personal liability status or whether the beneficiary had other medical coverage, such as private insurance. Consequently, Medicaid funds were used when "medically needy" beneficiaries or insurance programs may have been liable.

Minnesota - State or county agencies had not taken appropriate measures to ascertain third party liability on Medicaid claims. The State plan did not contain provisions relating to third party liability, nor did the State agency have information about policies and procedures followed by county agencies in complying with the Federal requirements in this respect. Our review disclosed that claims were paid as submitted and reimbursement was subsequently requested only when it was readily apparent that third party liability existed. Providers and counties did not have procedures for readily identifying certain categories of third party liability, such as Medicare or private health insurance coverage.

We recommended that the State plan be amended to provide reasonable measure for ascertaining when third party liability exists, and that policies and procedures be prescribed to the providers of medical services and to the counties for implementation of the plan provisions. We also recommended that third party liability be identified on the medical identification cards and on the recipients' payment records, that direct billing be made by providers to third parties whenever there is evidence of such liability, and that the State agency periodically review activities of the counties to insure that these procedures are effectively implemented.

Michigan Medical Service, one of the State agency's three fiscal agents, paid providers from Medicaid funds even though claim forms showed that recipients also had health insurance coverage under Michigan Blue Shield, the agent's private health insurance plan.

Michigan Medical Service reimbursed Medicaid funds after it checked eligibility and determined the amount payable under Blue Shield, but meanwhile Medicaid funds had been used needlessly and reimbursements from Blue Shield were untimely. At the time of our audit, about 5,000 claims totaling about \$400,000, of which the Federal share was about \$200,000, were outstanding. Some claims were more than a year old.

Texas - Procedures employed by the State agency and its fiscal agent were insufficient to determine third party liability on claims paid for medical services. The only source of information available to the fiscal agent regarding third party liability was a statement required of providers on the claim forms as to the existence of medical insurance. We noted numerous instances of refunds from providers to the fiscal agent on claims paid by the fiscal agent. The claims were originally paid on the basis of providers' statements that no other coverage existed. We believe that the existing procedures did not provide the control necessary to assure the absence of possible third party liability or the use of funds from such sources before payments were made from program funds.

Washington - The State agency had not collected the correct amount from the responsible third party in 20 percent of the cases we examined. Our review disclosed that improvement in processing third party liability cases was needed in several areas. There were (a) inadequate procedures for identifying potential third party liability cases when vendors used magnetic tape for billings, (b) clerical errors, and (c) incorrect interpretation of physicians' diagnoses. The State's ability to identify third party liability cases processed on magnetic tape would be improved if vendors reported accident related services on their billing form. A procedure to require vendors to indicate on all billings whether there is potential third party liability would reduce clerical errors.

The establishment of responsibility for the third party liability program at the county office level, rather than at the individual vendor level, would also strengthen control procedures. Such assignment of responsibility would eliminate the present fragmentation of these responsibilities among vendors, county offices, and responsible State organizations. This would provide the control necessary to assure that all billings are properly marked as to potential third party liability.

Timeliness of Claim Processing

Illinois - The Department of Public Aid (IDPA) did not pay all vendors of medical assistance within the time limitation prescribed by SRS.

Prior to July 1, 1967, Federal policy provided that financial participation was available in otherwise eligible medical payments provided not more than 12 months elapsed between the month of the latest service to an individual and the month of payment for the particular service. Effective July 1, 1967, the limitation was extended to 24 months.

During the period July 1, 1966, through September 30, 1968, medical payments made after the time limit had expired amounted to almost \$2.1 million, the Federal share of which was over \$1 million. Delays in paying medical providers' claims were attributable to (a) delays in receiving the bills, (b) rejection of invoices, necessitating return to vendors and reprocessing one or more times, and (c) weaknesses in methods of processing.

As a result of our audit, IDPA reduced its claim for Federal participation during the 30 months ended December 31, 1968, by \$2.55 million (Federal share \$1.27 million). The State agency also initiated data processing controls to identify medical payments made after 24 months from the date services were last provided.

Washington - Delays in processing and paying dental claims occurred because of the excessive time required to verify recipient eligibility. Thirty-seven percent of the dental claims we examined required 60 days or more to process and pay because the fiscal agent's magnetic tape system of providing data to the State agency was not incorporated into the State agency's machine accounting system.

ELIGIBILITY

Our review of the procedures for determining initial eligibility, recertifying eligibility, and operating the Quality Control (QC) program disclosed that in many of the States reviewed there is a need for improvements in these very important areas. Huge amounts of money are expended for medical aid on the basis of these certifications and management should take every precaution to ensure reliability.

Determination of eligibility and recertification of eligibility of individuals for Medicaid is governed by the provisions of the State plan approved by SRS. Quality Control is a procedure for review by the State agency of these medical eligibility case actions. The Handbook of Public Assistance Administration states that QC includes four general processes:

"(1) a continuous review of samples of local agency case actions throughout the State; (2) assembly and analysis of case action findings; (3) the planning and carrying out of corrective measures to deal with significant problem areas as they come to the State agency's attention; and (4) periodic assembly and reporting to the Administration of findings and results."

The Handbook further states that the focus of QC is on locating the types of errors frequently occurring in the program, determining why they occur, and bringing on the action by which they can be brought to a minimum level of incidence.

We found, however, that in 10 of 16 States audited one or more aspects of eligibility were not receiving appropriate attention from agency personnel. These lapses precluded assurances that only eligible individuals were receiving medical assistance. The following findings illustrate the major problems which require attention in order to improve the management of the Medicaid program at the State, local agency, and intermediary levels.

Declaration System for Eligibility Determination

New York - Since the inception of its Medicaid program, eligibility for medical services in New York City has been established through the use of a declaration system. Declarations are required to be validated by a subsequent full field investigation of a sample of the approved cases. Our review of the implementation of the system, based on statistical reports arising from the validation, showed these results:

1. The number of sampled cases closed because of ineligibility, or because eligibility could not be established, amounted to over 11 percent of the total caseload. Considering the overall monthly medical caseload of about 442,000 during calendar year 1968, it is likely that about 80,000 cases could similarly have been closed if they had been fully investigated.

2. These are not entirely new disclosures. City officials had enough information, before our review was made, to warrant corrective action by the city and State agencies. The need for prompt attention became even clearer after June 1968, when data under the present classification system became available. Nevertheless, there was

little evidence of any effective action by either the city or State agency to identify and analyze the factors contributing to the high case closing rate so that corrective measures could be explored. In addition, supervision and guidance furnished by the State agency were generally inadequate. Furthermore, no "action level" was established for the validation process until January 1969 (and then only on a limited basis) - more than 2 years after the Medicaid program was initiated.

Quality Control System

New York - The State agency's administration of the Quality Control program relative to New York City operations required improvement to assure management at all levels that surveillance of the determination of eligibility under the Medicaid program is adequate and that the required corrective action is promptly taken. We found that the State agency did not notify the city when QC reviews revealed deficiencies requiring prompt action so that corrective measures could be taken. In addition, lack of internal controls and other weaknesses at the city interfered with the proper assembly of case actions for the State, and thereby limited the value of the State's QC review. In this regard, controls were not established to ensure that all such actions were made available for review, the universe of actions was not maintained on a current basis, or prenumbered and arranged in chronological order as specified by Federal requirements, and the field of QC actions was incomplete because one category of actions (Medical Assistance-Home Relief Cases) was omitted from the monthly universe. As a result, there was no assurance that the sample selected for review was unbiased or that the results of the sample were statistically effective.

California - Our review showed that quality control schedules were not tabulated and analyzed on a current basis. As a result, timely identification of the causes and correction of significant problems in the determination of medical eligibility had not been made.

As of the date of our examination, the State had completed reviews of 290 of the 450 positive actions required for medical eligibility for the 12-month period ended March 31, 1969. In 49 of the 290 cases, or 17 percent, the county had erred in computing the recipient's share of medical costs. The recipient's share was understated in 37 cases and overstated in 12. Of the 49 defects, 24 were attributable in some degree to the recipient stating his resources incorrectly in the declaration statement on which eligibility is established. This rate of error is similar to that disclosed by a State review of the declaration system, which showed that only about

one-half of the applicants' declaration statements agreed with the results of a subsequent investigation and about 20 percent disclosed an error in the share of cost for medically needy only cases. This figure is comparable to the 17 percent figure noted in our review of the QC case actions. In addition, county welfare staffs were responsible in some degree for 35 of the 49 defects. Local agencies did not always correct medical eligibility errors brought to their attention during the State's QC review. In Santa Clara County two of five defects had not been corrected. In one case the county had established the recipient's share of medical costs as \$71 per quarter whereas the QC reviewer determined it should have been \$722. In the other case the QC reviewer determined the recipient's share should have been \$135 per quarter instead of \$3 as computed by the county. As of the date of our review, which was 10 weeks after the county was notified of the second defect, the county had not corrected the recipient's eligibility card or updated the State's eligibility file.

We recommended that the State agency (a) tabulate and analyze the QC results more frequently, (b) take corrective action promptly when indicated by the analysis, and (c) establish controls to assure corrective action by the local agencies.

Pennsylvania - The State agency had no controls to assure that all required case actions were reported to the State office by local agencies. As a result, there was no assurance that the universe from which the State's QC statistical sample was selected, was complete. Case actions reported by some local agencies were limited to applications for Medicaid and did not include redeterminations of eligibility or terminations.

In addition, we found that local agencies were not always notified of the State's quality control review findings, nor were they required to report actions taken when defects were brought to their attention. Furthermore, the QC director was not notified promptly when the rate of case action error reached a level that would require him to act, nor was the program manager always informed of the results of the QC review.

Illinois - Our review of the State's system of quality control of case actions on medical eligibility disclosed that: (a) Nine of the 33 cases that we reviewed had delays of over 60 days. It took up to 111 days to complete reviews of some case actions. (b) The annual statistical report on quality control did not agree with the supporting detail. The report showed that 736 case actions were examined and that 912 defects were found, but the supporting detail showed 1,184 actions and 1,182 defects. (c) Twelve "Quality

Control of Case Actions" forms were missing from the 33 cases in our sample. Federal policy requires that the records necessary for preparing statistical reports, including these forms, be maintained.

Texas - The State agency had not extended its quality control procedures to cover Medical Assistance only cases. The exclusion of this large number of cases (about 17,000 at February 1, 1969) from the review system significantly detracts from satisfactory control over the process of eligibility determinations. We recommended that the quality control review be extended to cover these cases.

Redetermination of Eligibility

Wisconsin - The State agency's supervision over county agencies' redeterminations of eligibility was inadequate. Three of five counties we visited had not made timely redeterminations of eligibility in certain cases. One county had not acted on some cases for as long as 6 months after expiration of eligibility. Furthermore, the county agencies failed to notify appropriate fiscal agents that eligibility had terminated for these recipients, and as a result payments were made for services provided to ineligible persons. Of the 119 cases for whom redetermination of eligibility had not been made, we noted that medical payments had been made for 17, or 14 percent of the total.

Our audit further disclosed that many case records did not include required forms documenting casework actions, therefore there is no assurance that such actions were initiated. Of the 60 case records examined, 3 did not include the "Notice of Approval for Medical Assistance," 38 did not include the "Notice of Expiration of Certification for Medical Assistance," and 39 did not include the "Notice of Continuing Eligibility for Medical Assistance."

We recommended that a refund be obtained for medical payments made in behalf of individuals whose eligibility had not been redetermined within the prescribed time limit, that controls over county agencies be strengthened to ensure compliance with redetermination of eligibility requirements, and that case files be fully documented with copies of the decisions on eligibility sent to the applicants.

Payment for Medical Services to Ineligible Recipients

Michigan - We estimated that payments of approximately \$2.1 million (\$1.05 million Federal share) were made by the Michigan State Agency, through its fiscal agent, Michigan Medical Service (MMS), for services to ineligible recipients. This occurred when

the State agency, in August 1967, discontinued requiring eligibility determinations by MMS prior to payment of medical claims.

Experience indicated that about 30 to 60 days elapsed between the time that a person was determined to be eligible by the county and the date his name appeared on the monthly list of eligible recipients prepared by the State agency and furnished to MMS. Also, providers had made mistakes in recording the recipients' identification numbers. These factors created a backlog of providers' claims, causing complaints about delay in payment. As a result, the State agency changed its procedures and instructed MMS to make payments in these instances but to identify them separately and to submit weekly listings of such paid claims so that the State agency could subsequently followup and take whatever action was necessary.

Of the 74 weekly listings forwarded to the State agency during the period August 1967 to January 1969, the State agency had checked eligibility for claims of over \$10 on only 17 of the listings, 42 had been partially completed, and 15 had not been started at the time of our review. No adjustment had been made for the claims known to have been paid on behalf of the ineligible recipients.

For the 17 listings that had been completed, \$323,764, or 40 percent, of the claims examined by the State agency on these listings was paid on behalf of ineligible recipients. Based on a projection of the results of the State agency's analysis of these 17 listings, we estimate that almost 200,000 claims totaling about \$2.1 million were paid on behalf of ineligible individuals during the period August 1967 to January 1969. We recommended that the State discontinue making payments prior to determining eligibility and that the Federal share of payments made to ineligible individuals be refunded to the Federal Government.

California - During the 22 months ended December 31, 1967, the State used about \$897,000 in Medicaid funds to pay for diagnostic services for crippled children. SRS regulations provide that although the Medicaid program can pay for medical services to crippled children, it cannot pay for diagnostic services. Under the crippled children's program, diagnostic services must be made available without charge and without restriction or requirement as to the economic status of the child, his family, or relatives. We recommended that the State agency stop using Medicaid funds to pay for these services and that the State refund the Federal share of Medicaid funds already used - about \$448,500.

OTHER PROBLEM AREAS

Our review disclosed instances of weaknesses or deficiencies in a variety of areas. Although some of the weaknesses were not directly related to the segments of the program we reviewed, they affected management of the program in varying degrees and in one or more ways. In other situations, findings were unique to one State, but in our opinion were of substantial significance. While the impact of these problem areas is not always measurable in terms of money, we feel that they significantly affect the program and that the State agencies should take corrective action. Also, we believe that it is possible that these or similar situations may exist in other State agency Medicaid programs. We recommend that the Social and Rehabilitation Service, through program reviews and other surveillance techniques, assure itself that if these situations do exist in other State agencies, corrective action is initiated.

The following examples are illustrative:

Special Claim for Outpatient Costs

New York - The State agency claimed \$29.8 million, of which \$9.7 million was the Federal share, for the cost of outpatient visits at New York City municipal hospitals under the Medicaid program during the period May 1, 1966, to June 30, 1967. The validity of the claim could not be established.

From the inception of the Medicaid program in May 1966 to June 30, 1967, the City of New York failed to determine, on an actual basis, the number of outpatient visits to municipal hospitals by Medicaid recipients. By June 1967, the volume of this data was so great that the State asked HEW to accept the results of a sample of visits made during July through December 1967, to apply retroactively in determining eligibility and cost distribution among the Federal, State, and city agencies. HEW agreed, provided that the sampling specifications it established were followed. Our review disclosed that none of these specifications were followed satisfactorily.

The overall results of the sample as reported by the city were inaccurate because the city did not satisfactorily control and monitor a scientific sample and the State did not supervise the city's computations. We estimated that of the 9,415 visits sampled by the city, about 772, or 8.2 percent, were erroneously coded and classified and about 470, or 5 percent, of the cases would be unavailable.

Cost of Mental Health Services

Illinois - We could not determine the acceptability of amounts claimed for providing services to eligible patients in State mental institutions during the period January 1, 1967, through June 30, 1968. This was due to uncertainties as to whether the entire amount incurred by the State for these charges was allowable or only the amount of the previously established monthly maximum charge of \$132 per patient. The difference in Federal participation amounts to over \$10 million.

The Illinois Mental Health Department code provided that each patient receiving treatment in a mental health program of the department, and the estate of such patient, is liable for the payment of treatment charges. The rate is calculated by averaging per capita cost of operation of all State hospitals for the fiscal year immediately preceding the period of care for which the rate is calculated, except that the State may at its discretion bill at a lesser amount than such average per capita cost. If the patient, his estate, or the responsible relative are unable to pay, the cost is borne by the State. The rate of \$132 was applicable for the period July 1 to December 31, 1966. However, on October 25, 1967, the State changed its procedure to provide that for calendar year 1967 the maximum charge for treatment of patients in State hospitals who are 65 or over and eligible for benefits under Titles XVIII or XIX of the Social Security Act, is the actual per diem rate cost of the hospital providing treatment. These rates ranged from \$207 to \$1,507 a month. The maximum charge for treatment to be assessed against a patient not eligible under Titles XVIII and XIX remained \$132 per month.

This created a situation where (a) the State differentiated between patients eligible for Title XIX and those who were not, (b) a question may exist about supplanting State funds with Federal funds, and (c) the rate for individuals eligible under Title XIX was increased retroactively to January 1, 1967.

We recommended that appropriate determination be made about the allowability of the amount of Federal participation claimed for cost of services rendered to patients in the State mental institutions.

Contract with Blue Cross-Blue Shield

Texas - The State Department of Public Welfare (TSDPW) contracted with Group Hospital Services, Inc. (GHS), operated by Blue Cross-Blue Shield of Texas, to process and pay claims of hospitals and physicians for medical services rendered to Medicaid

recipients. Three contracts, covering different groups of people, were approved by SRS and incorporated into the State plan effective September 1, 1967, when the Medicaid program became effective in Texas. TSDPW considered these contracts to be a health insuring arrangement in accordance with the provisions of the State plan.

The terms provided for monthly premium payments by TSDPW for each Medicaid recipient. A specified amount of the premium is designated as compensation to GHS for plan services. The premium rate, including the portion applicable to plan services, is subject to adjustment at the request of either party. Any adjustment in the premium rate would be retroactive to the inception of the contracts and would be calculated so that total cost of the adjusted premium rates would equal the sum of the total benefit costs plus total plan services costs. The contracts further provide that following termination of the contracts, GHS will repay to TSDPW any sum by which total premiums exceed total benefit and plan services costs. We did not analyze or review GHS administrative costs, but we did attempt to determine the equity of the premiums designated for such costs. We found that the only information provided TSDPW as the basis for determining GHS administrative costs was a one page summary of estimated costs which totaled over \$3 million. The summary listed 10 administrative cost items, one of which was "provider audits" at an estimated cost of \$225,000. As of the date of our audit, no provider audits had been made and there were no firm plans to make any.

Another item was \$1.2 million for "data processing." This represented the estimated cost of computer services to be furnished GHS by the Electronic Data System Corporation (EDS). A contract between GHS and EDS provided for a two-phase operation. Phase I consisted of preinstallation activities at a cost of \$62,580. Phase II related to the regular ongoing computer services provided to GHS. The cost for this service was a monthly charge based on the number of processed claims. The rate per claim changed at certain prescribed volume levels. However, there was no documentation available to show the relationship between estimated costs expected under the terms of the contract, and the \$1.2 million included in the premium rate computation.

We noted other items on the list which represented a portion of joint costs, the total of which was shared between GHS and other Blue Cross-Blue Shield activities. One such item in the amount of \$260,000, was for "executive, administrative, and legal" costs. However, no plan of allocation was requested by or provided to

TSDPW, either before or after the contracts were negotiated with GHS, by which it could be determined whether the amount charged for these services was reasonable and equitable.

While no historical program cost information was available on which to base the initial premium rates, we believe that they should have been based on objective criteria supported by detailed documentation. We also believe that the administrative cost portion of existing contracts should not have been extended for an additional 12 months beginning September 1, 1968, without considering actual program costs generated during the first year of operations.

We recommended that the TSDPW review the basis for reimbursing GHS. Payments to GHS should be based on objective cost data, adequately supported by detailed documentation, and should bear a reasonable relationship to the actual cost of providing the services.

The contracts do not clearly present a well defined arrangement as prescribed in the Handbook of Public Assistance Administration, so we asked the Office of the General Counsel to examine the contracts to determine whether GHS functions as a fiscal agent or as a health insurer. General Counsel's opinion was that GHS is the fiscal agent of the Texas Department of Public Welfare.

Some significant effects of the opinion follow:

1. During the 10 months ended June 30, 1968, the portion of total premiums paid to GHS for administrative services was almost \$3 million. The State claimed Federal participation at 79.78 percent, but as a fiscal agent of TSDPW, GHS administrative costs should have been claimed at the rate of 50 percent. Therefore, TSDPW overstated its claim for Federal participation by about \$888,000.
2. TSDPW's claim for Federal participation in medical service costs was based upon premium payments made to GHS rather than actual expenditures for medical services provided. During the period September 1, 1967, through June 30, 1968, TSDPW premium payments to GHS for medical services totaled almost \$33 million. During this period, however, GHS disbursed less than \$19 million to vendors for medical services to Medicaid recipients. The Federal share of medical services costs was therefore overstated by \$11.2 million.
3. Contracts between TSDPW and GHS make no provision for TSDPW approval of subcontracts and inspection of related financial records. Control over third-party agreements is necessary to comply with the single State agency concept of program administration. We

found no evidence that TSDPW assumed this responsibility with respect to subcontracts, and therefore it has no way of ensuring that operations under such arrangements meet Federal requirements. SRS policy specifically states that the State agency has continuing responsibility for the quantity, quality, utilization, and payment for services provided to recipients, whether the agency makes arrangements directly with the vendors or uses an agent to make these arrangements. This is a responsibility which a State agency may not delegate.

4. TSDPW's review of GHS claim processing procedures was inadequate. The review, consisting of computer verification of the contractor's computer tapes of claims paid, did not provide assurance that GHS was paying only those claims for services covered by the State plan, or that established criteria were followed in determining amounts payable to medical vendors.

We recommended that TSDPW amend its agreements with GHS to clearly establish either an agency or health insuring arrangement. We also recommended that until such time as the contracts are amended, the State agency consider GHS a fiscal agent and make the necessary retroactive adjustments for Federal funds claimed in excess of those allowable under such an arrangement; revise its reporting procedures by appropriately reporting GHS administration costs at the allowable 50 percent rate; restrict assistance costs to actual amounts expended for medical services; and discharge its responsibility as a single State agency in the review and control of GHS operations pertaining to the Medicaid program, including procedures for ensuring that expenditures are made only for services included in the plan and that payments to vendors are allowable and unduplicated.

Since the issuance of our Texas audit report, the State negotiated a new contract with GHS which is currently under review by SRS officials and the excess balance of premium payments on hand with GHS has been eliminated by withholding premium payments due for February, March, and April 1969, and by paying the medical costs from the excess balance. The basic question of whether the contractual arrangement between the State and GHS represents a health insurance or a fiscal agency relationship as a basis for settlement of the question presented in item 1 above is now under close study by SRS officials.

Income Tax Information Returns

New York - The New York City Department of Social Services did

not furnish information returns to the Internal Revenue Service (IRS) and to practitioners paid for professional services to Medicaid clients. This can weaken IRS's verification procedures with respect to income tax returns. Similarly, NYCDSS did not file information returns with New York State and New York City.

The Internal Revenue Code requires that when payments for services totaling \$600 or more to any person are made during the calendar year, IRS must be notified. The State and city have similar requirements. NYCDSS said it was not aware of these requirements and we noted that NYSDSS had issued no instructions advising localities to conform with the Internal Revenue Code and applicable State and local regulations.

NYCDSS makes substantial payments to medical service practitioners. During calendar year 1968, for example, more than 12,700 physicians and dentists received over \$123 million for services to Medicaid recipients. In addition, \$62 million more was paid to such other independent practitioners as optometrists, pharmacists, and nurses.

We recommended that NYCDSS comply with tax regulations and report payments made to outside practitioners under the medical assistance program. We further recommended that NYSDSS advise all social services districts in the State of this requirement and instruct them to comply with the tax laws.

Fund Balances

An examination of the manner in which States operated the letter-of-credit system was not one of the principal objectives of our audit, but our reports do show that several States kept on hand large and often long-standing excessive balances of Federal funds drawn on letters of credits issued under the Medicaid program. This area further illustrates general problems in fiscal administration of the Medicaid program. Two examples follow:

New York - The New York City Department of Social Services was very slow in crediting the Medicaid program with refunds from such sources as health insurance plans, workmen's compensation, liability actions against third parties, and refunds from hospitals for overcharges disclosed in audits by the City Comptroller. At December 31, 1968, unprocessed credits had reached \$15 million, which the Federal share was about \$5.3 million. Some of these credits were more than 2 years old.

The Medicaid program began operations in New York State in October 1966, but NYCDSS made no effort to process any credits until March 1968. At September 30, 1968, the backlog of unprocessed credits was estimated at 30,000 and although the Department was processing about 2,000 credits a month, by the end of February 1969 the backlog had jumped to almost 34,000. The city says it has added more employees in the processing section, is now processing about 3,000 transactions a month, and has reduced its backlog to 20,000.

California - The checking account used by a State fiscal agent to pay medical claims always had a large number of checks outstanding. The average amount outstanding during 1967 was \$8.4 million, half of it Federal. The State agency deposited into this account the exact amount of claims it had approved for payment, without regard to the balance of outstanding checks. We recommended that sight drafts, instead of checks, be used to pay claims. Under this procedure funds would not have to be deposited until the drafts were presented for payment, thus reducing current cash requirements for both State and Federal Governments.

IV - REVIEW OF REGIONAL AND HEADQUARTERS ADMINISTRATION

REGIONAL OFFICE ADMINISTRATION

The Office of Associate Regional Commissioner for Medical Services is responsible for administering the Medicaid program at the regional level; it is a vital link between Medical Services Administration headquarters and the State grantee agency in the Department's administration of the program. The regional office is charged with providing leadership in the planning and execution of plans in the States, reviewing and evaluating State programs, and consulting with and assisting the States. The effectiveness of HEW administration is measurable largely by the way in which the State agencies conduct the programs, and a breakdown at the regional level could adversely affect the program. We reviewed regional office administration in the six regions in which we audited State programs.

Important factors in ensuring effective management at the regional level include: (1) sufficient staff, (2) clear lines of communication between this staff, the central office, and State agencies, and (3) definitive guidelines relating to policies, procedures, and goals. Our review of these areas disclosed weaknesses which need to be corrected if the regional offices are to increase their effectiveness. These weaknesses are discussed under the following headings:

Program Evaluation and Surveillance
 Followup on Program Review and Evaluation Projects
 Plan Approval

Program Evaluation and Surveillance

Except for those evaluations made in cooperation with Central Office Program Review and Evaluation Projects (PREP), regional offices made only limited program evaluations of State operations, if they made any at all. This situation existed in varying degrees at most of the six regional offices that we reviewed.

Region V, where the staff consisted of two persons, was fairly typical. The Medical Services staff was required to operate generally on the exception theory of management, with attention being devoted essentially to problems as they arose, rather than under a positive ongoing management concept. The regional office staff, therefore, did not actively participate with State agencies in significant areas. For example, Section 1903(e) of the Act requires State agencies to make a satisfactory showing in the direction of broadening the scope of care and services available under its plan, and Medical Services staff is required, among other things, to (1) evaluate community and agency resources, needs and capabilities with respect to personnel, facilities, services, and finances; (2) stimulate and innovate new programs and changes or expand existing programs; and (3) assist in development of personnel standards, cooperative agreements, and contracts for services and facilities. We found little evidence that the Regional Medical Services staff had been involved in these areas, nor did we find records showing that these goals were being pursued.

Similarly, Section 1903(b) of the Act provides for maintenance of effort by States in providing mental health services as a condition precedent to Federal financial participation, and Federal policy provides methods for determining maintenance of effort on the basis of expenditures. Generally, Medical Services staff had made no effort to obtain from State agencies expenditure or other data necessary to evaluate the maintenance of effort in mental health.

The basic job descriptions at one regional office indicated that the Medical Services staff should assume an active leadership role in the program, but we found that the staff acted mainly as a liaison between the central office and the State agencies.

Recommendation

We recommend that regional office operations be studied to determine how best to use the limited manpower available and consideration be given to increasing the size of the staff.

Followup on Program Review and Evaluation Projects (PREP)

PREP reviews of State agency operations to appraise the State's effectiveness in operating the Medicaid program were made by Central Office Medical Services staff with the cooperation and assistance of Regional Medical Services staff. The central office prepared the reports and forwarded them to the regional office. The regional office sent the report to the State agency with a request for its comments, and was responsible for ascertaining whether the State agency followed recommendations made in the report.

The findings and recommendations, however, were generally not discussed with the State on a timely basis, and when they were discussed the results were frequently not discernible or were not documented. From 3 to 9 months would elapse from the receipt of the report by the State to followup by the regional office. The following examples are illustrative:

New Mexico - A PREP report was sent to the State agency in July 1968, with the State being given 60 days to report on corrective action taken. When 6 months had passed without an answer, Central Office Medical Services asked the regional office to follow up with the State. The regional staff called New Mexico in January 1969 and wrote to them in February, but by the end of March the State still had not replied and there was no information about any action the State had planned or taken.

Washington - The PREP report, containing 18 recommendations, was forwarded to the State in June 1968, 8 months after the October 1967 review was made. The State responded in July 1968, but the regional office staff did not visit the State to discuss the report until January 1969. At the time of our audit in April 1969, the State had completed action on only four items, partial action had been taken on six items, and there had been no action on the remaining eight.

Michigan, Wisconsin - Four months after releasing the Michigan PREP report, and 3 months after sending Wisconsin its report, the regional office staff had not visited these States to discuss the findings and recommendations.

Recommendation

We believe that PREP reviews can be highly effective in achieving a sound and efficient Medicaid program and at the same time inform management about strengths and weaknesses in administration. However, sound management practices require timely action on problems of a critical nature. Failure to follow up on known deficiencies may reduce

the effectiveness of the findings and result in the State agency continuing to use deficient or ineffective procedures.

Plan Approval

Our review disclosed that the Dallas regional office approved an arrangement between the Texas State Department of Public Welfare and Group Hospital Services, Inc., which did not meet the requirements of Supplement D of the Handbook. Details of this agreement, its impact on the administration of the Medicaid program, and the problems it presented are covered in "Other Problem Areas" in this report.

Although the arrangement was approved by a predecessor agency before the Regional Medical Services Staff was established, we believe that the regional staff should have recognized that the contract did not meet MSA requirements and should have initiated corrective action. This situation, while unique, emphasizes the need for strong regional office administrative procedures, and demonstrates how weaknesses at the regional level can affect the program adversely.

HEADQUARTERS ADMINISTRATION

The Office of the Commissioner, Medical Services Administration (MSA), staffed by about 50 professional and 35 support personnel, is responsible for administering the Medicaid program at headquarters. Some MSA responsibilities are to establish program goals and objectives; develop standards, program policies, criteria, and guidelines; and provide professional consultation to the regional office staff and assist in the guidance and leadership of State and local agencies. We noted that MSA was not able to effectively discharge all of its responsibilities, primarily because it was inadequately staffed. MSA informed us that the considerable amount of time devoted to answering inquiries about the program from various sources, including State agencies, medical providers, and professional associations, diverted headquarters from its other responsibilities.

Our review of these areas disclosed weaknesses which need to be corrected if the headquarters office is to increase its effectiveness. These weaknesses are discussed under the following headings:

Functional Responsibilities

Regulations and Guidelines Implementing Certain Provisions of the 1967 Amendments to the Social Security Act

Program Review and Evaluation Project Reviews

Coordination Between Associate Regional Commissioners
and Central Office

Functional Responsibilities

Functional statements about responsibilities, although not officially approved, indicated that divisions and branches were delegated specific responsibilities, but we found that many of these delegated responsibilities had not been discharged. The following examples are illustrative:

The Fiscal Standards Branch was given responsibility to (1) develop policies and set standards for the fiscal management of State agencies and fiscal aspects of Federal matching funds, and (2) establish procedures and formulate methods and principles for fiscal accountability, disbursement of funds, and financial controls and reports. No guidelines had been issued at the time of our review; only a State letter dealing with allowable administrative costs under the 50 percent and 75 percent matching formula had been prepared in final draft.

The Health Economics Branch (HEB) of the Medical Program Management Division was assigned responsibility for conducting studies on medical and dental costs, hospital inpatient and outpatient costs, laboratory and X-ray services, drug and pharmacy costs, home health agency care, and all other elements of the medical care spectrum. These studies were to ascertain current and future costs of State programs by analyzing such aspects as the percentage share of Federal and State expenditures by type of service, population groups, fee schedules, and prevailing rates of charge. The studies would serve as a useful tool in analyzing and controlling medical costs, but no studies were ever made. We were informed by HEB that most of their time was devoted to day-to-day problems, "putting out fires," and answering questions about the Social Security amendments.

The Management Branch was assigned responsibility for developing and establishing methods, procedures, and guides for improving operations and management techniques; conducting management surveys of institutions; testing management and fiscal systems; and developing, designing, and implementing systems of ADP and EDP applications. We were informed that except for the preparation in draft form of guidelines on utilization and reviews, and payment of reasonable charges for drugs, none of the above functions had been fulfilled.

The State Evaluation Guides and Standards Branch of the Medical Program Evaluation Division (MPED), was assigned responsibility

for development of evaluation guides and standards for State agency use in evaluating utilization and quality of medical and remedial care and services provided to recipients. MPED was also responsible for developing national standards and criteria for the determination of quality control effectiveness of the health care services made available to Medicaid recipients. But no guidelines, standards, or criteria had been established and MPED informed us that this was due to limited manpower.

Recommendation

We recommend that MSA review its manpower resources, identify its top priorities in terms of workload requirements, and determine whether its available manpower is being used to the best advantage.

Regulations and Guidelines Implementing Certain Provisions of the 1967 Amendments to the Social Security Act

The 1967 amendments to the Social Security Act added many new provisions and requirements to the Medicaid program. At the time of our review, MSA had published 13 regulations in the Federal Register and two interim policy statements implementing certain provisions of these amendments. Four additional regulations in draft form remained to be issued, one of which was issued on June 24, 1969, after completion of our review. The remaining three regulations are awaiting clearance.

We also found that MSA had not published implementing guidelines for several Medicaid regulations; these are needed because many of the regulations which had been issued were not sufficiently comprehensive to provide meaningful assistance to the States. The primary purpose of the regulations and related guidelines is to help the States operate the Medicaid program effectively and efficiently. We believe that MSA should develop and publish the remaining regulations and guidelines as soon as possible.

MSA attributed failure to publish the regulations and guidelines on a more timely basis to lack of adequate staff and the time-consuming procedure required for getting draft material cleared by numerous interested offices.

Recommendation

We recommend that MSA give priority to issuing detailed guidelines, where necessary, to clarify and implement the requirements of the amendments to the Act, and that an effort be made to reduce the amount of time now required for processing and clearing draft regulations and guidelines.

Program Review and Evaluation Project Reviews

PREP reviews, as described under Regional Office Administration, were not made frequently enough to identify for management, on a timely basis, aspects of State programs in need of improvement. Moreover, MSA did not establish formal followup procedures to ensure that States acted on deficiencies identified through the PREP reviews.

During August 1967, MSA instituted an internal policy providing for one PREP review to be made each month. At this rate, almost 4 years will be required to review all States and jurisdictions participating in the program. Although 24 PREP reviews had been made as of May 1969, 16 States and 3 other jurisdictions had not been reviewed. MSA stated that with only seven professionals available in the Medical Program Evaluation Division, not more than one PREP review can be made each month. These seven cannot devote full time to the PREP activity because of their other responsibilities.

Several areas where we believe that the PREP operation could be strengthened through the utilization of formal procedures are discussed below:

Beginning in July 1968, MSA policy provided that State agencies must submit an action report within 60 days after they received the PREP report. MSA, however, did not provide written procedures to be followed when a State failed to respond within the 60-day limitation. Our review disclosed that from the date MSA published a PREP report, an average of over 4 months elapsed before the State agency submitted the required action report. Of 18 PREP's that required action reports in May 1969, 5 were at least 6 months overdue.

MSA policy also provides that the State agency will be responsible for preparing the action report. Three of five action reports that we examined had been prepared by MSA regional personnel; they were basically summaries of conversations that took place during the regional employee's visit to the State agency to discuss PREP recommendations. MSA accepted the reports prepared by regional personnel and considered that its policy requirements had been met, but our review disclosed that generally these reports were only partially responsive to the PREP report.

MSA had no written instructions on how to handle action reports from the State agency that were not responsive to the findings in the PREP report. We were informed that many questions of this kind were handled by telephone with the Associate Regional Commissioner, but we saw no evidence of the nonresponsive report having been revised, nor did we see records of telephone conversations.

Recommendation

We recommend that MSA issue specific instructions and delegate responsibility for (1) evaluating the action reports to determine that they respond to recommendations in the PREP report, (2) initiating uniform followup action when necessary, within a defined time frame, and (3) certifying when final and appropriate action has been taken on each PREP review.

Coordination Between Associate Regional Commissioners and Central Office

Coordination of activities between the MSA Regional Offices and Central Office needed to be strengthened. Neither office was fully informed about the results of the day-to-day operations of the other office, so management was not apprised of potential or actual problems which needed action. A contributing factor was the lack of uniform instructions, guidelines, or procedures that defined and explained the responsibilities of the regional office in carrying out program objectives. MSA Central Office personnel informed us that regional office responsibilities were defined only in individual job descriptions. The regional office mission had not been precisely defined and because there was no apparent effort to coordinate the daily activities, there is reason to believe that these activities vary among the regions.

Recommendation

We recommend that detailed instructions and guidelines be issued to clearly define the mission and responsibility of the region so as to strengthen the overall administration of the program.

Exhibit A

Expenditures by State for the
Period January 1, 1966, through December 31, 1968

	<u>Date</u> <u>State Began</u> <u>Operation</u>	<u>Total</u> <u>(In millions - rounded to nearest million)</u>	<u>Federal Share</u>	<u>State and</u> <u>Local Share</u>
<u>Region I</u>				
Massachusetts	Sept. 1966	\$ 410	\$ 205	\$ 205
New Hampshire	July 1967	5	3	2
Rhode Island	July 1966	53	29	24
<u>Region II</u>				
New York	Oct. 1966	2,136	798	1,338
Pennsylvania	Jan. 1966	415	202	213
<u>Region V</u>				
Illinois	Jan. 1966	368	184	184
Michigan	Oct. 1966	329	165	164
Wisconsin	July 1966	240	136	104
<u>Region VI</u>				
Minnesota	Jan. 1966	231	137	94
Missouri	Oct. 1967	45	28	17
<u>Region VII</u>				
Oklahoma	Jan. 1966	190	133	57
Texas	Sept. 1967	174	130	44
New Mexico	Dec. 1966	27	19	8
<u>Region IX</u>				
California	March 1966	1,704	857	847
Oregon	July 1967	26	14	12
Washington	July 1966	125	61	64
		<u>\$6,478</u>	<u>\$3,101</u>	<u>\$3,377</u>
Other States		<u>\$1,066</u>	<u>\$ 634</u>	<u>\$ 432</u>
Total		<u>\$7,544</u>	<u>\$3,735</u>	<u>\$3,809</u>

ANALYSIS OF AUDIT OBSERVATIONS BY STATETITLE XIXSOCIAL SECURITY ACT, AS AMENDED

Weaknesses noted during our audits were principally in the following categories:

	<u>Management Controls</u>	<u>Procedures for Processing Claims</u>	<u>Eligibility</u>	<u>Other Problem Areas</u>
<u>Region I</u>				
Massachusetts	X	X	X	-
New Hampshire	X	X	X	X
Rhode Island	X	X	X	-
<u>Region II</u>				
New York	X	X	X	X
Pennsylvania	X	X	X	-
<u>Region V</u>				
Illinois	X	X	X	X
Michigan	X	X	X	-
Wisconsin	X	X	X	-
<u>Region VI</u>				
Minnesota	X	X	X	-
Missouri	X	-	-	-
<u>Region VII</u>				
New Mexico	X	X	-	X
Oklahoma	-	-	-	-
Texas	X	X	X	X
<u>Region IX</u>				
California	X	X	X	X
Oregon	X	-	-	X
Washington	X	X	X	X
Minimum question- able dollar impact (in millions)	\$97	\$25	\$126	\$70

APPENDIX D

A Description of the Medicaid Watchdog System

APPENDIX D.—A DESCRIPTION OF THE MEDICAID WATCHDOG SYSTEM¹

What is the "Watchdog" System?

The Medicaid "Watchdog" System is a method of insuring that high quality health services are provided to beneficiaries of the Medicaid Program in New York City. The system is meant to be educative and not punitive, and it attempts to upgrade the quality of health services rendered in Medicaid.

Why a "Watchdog" System?

The Medicaid Program in New York City represents the largest publicly-funded health care program in the country. In 1968, over 750 million dollars was expended for health services in New York City. This represents an average expense of \$300 per enrollee.

The "new" components of Medicaid are the inclusion of "private sector" care and the free choice of this care. Included in health services, over and above basic hospital in-patient and out-patient care, and nursing home care (which has been traditionally available in N.Y.C. prior to Medicaid), are services of physicians, dentists, optometrists, podiatrists, chiropractors, pharmacists, opticians, appliance dealers, hearing aid dealers, and rehabilitation therapists.

In New York City, there are some 35,000 various providers of service in the above groups, all eligible for participation. With the variety of services available and the amount of providers of service, monitoring devices as to standards and performance had to be developed. In addition, the fees paid to providers compared favorably to those fees paid under other programs; hence, public monies had to be accounted for in terms of quality and quantity of service.

What Is the Authority for the "Watchdog" System?

The Health Department of New York City derives its authority for the "watchdog" system through administrative interpretation of the Title XIX legislation, specific references in the Title II of the New York State Social Welfare Law (New York's Medicaid Law), and through legal authority as spelled out in the contractual arrangement between the New York City Health Department and the New York State Health Department to administer the Medicaid Program locally.

Title 19.—Section 1902(a) (a) "provide for establishing and maintaining standards for private or public institutions * * *"

Title 11.—Section 363: "* * * promote State's goal of making available to everyone, regardless of race, age, national origin or economic standing, uniform, *high-quality* medical care."

Section 364, 2. (e) "reviewing and auditing the quality and availability of medical care and services rendered under local public welfare medical plans * * *"

¹ Provided by N.Y. City Dept. of Health.

Agreement, dated April 1, 1967, between the State Health Department and New York City, paragraph 1C: "the periodic review and audit of the quality and availability of medical care and health services required to be furnished to recipients of medical assistance * * *."

How Does the "Watchdog" System Work?

The system encompasses three basic program areas in health care:

1. Standard setting
2. Surveillance
3. Enforcement

1. *Standard Setting*.—Standards are set for each of the health care areas, such as physician care, dental care, optometric care, etc. by means of sessions with appropriate advisory committees. These committees have representatives from practicing professionals, faculty members from pertinent professional schools, and representatives from organized professional societies. Through a frank interchange of ideas, quality standards are written and reviewed. They then become Professional Guidelines after review by the State Health Department and are subsequently distributed to the profession as "work manuals." Modifications to these standards are arrived at in the same manner and are also distributed.

These standards, then, become the benchmarks against which performance is evaluated.

2. *Surveillance*.—The purposes of surveillance are as follows:

- a. Assess level of care.
- b. Document areas of deficiencies.
- c. Strengthen *existing* mechanisms by consultation, post-graduate education, etc.

Surveillance is conducted in a number of ways and may result from any number of sources, such as patient complaints, invoice review, random sampling, etc. One innovative method used by the New York City Health Department is "audit-tolerance levels." Based on data derived at the Advisory Committee meetings, each provider of service has an "audit-tolerance" level which is the translation of services into dollars. For example, it is generally agreed that a physician should and cannot see more than 40 patients in a day in his office if he maintains quality. This, translates into \$5,000 a month for a general practitioner. Therefore, all physicians whose payments exceed this amount are "red-flagged" for review. The \$5,000 figure could be justified in any number of ways; however, the Health Department initiates follow-up as a matter of routine.

Similar "audit-tolerance" levels have been set-up for other provider groups:

- Dentists: \$5,000 per chair
- Optometrist: \$4,500 per month
- Podiatrist: \$3,500 per month
- Pharmacist: \$3,000 per employed full time pharmacist 1 month
- Chiropractor: \$2,500 per month

(a) *On-site audits* of private professional facilities where health care is given. This takes the form of visits by professional peers to offices of physicians, dentists, optometrists, podiatrists, health centers, etc.

(b) *Evaluation of medical records* at the treatment facility. The purpose of this is to determine the general nature of care given, an estimate of the quality, and an indication of the use of referrals (x-ray, laboratory) and consultations.

(c) *Examination of patients* for whom services have been given. A sample of patients is selected, and the work performed, whether it is dental, optical, podiatric, etc. is evaluated and compared against the invoice submitted by the professional. This gives overall qualitative data as to the following:

- (1) Accuracy of diagnosis
- (2) Appropriateness of treatment
- (3) Necessity of procedures
- (4) Adequacy of prostheses, such as dental bridges, orthopedic shoes, eyeglasses, etc.

(d) *Follow-up of complaints* by patients is pursued in determining quality of care. Indeed, the Health Department encourages patients to voice complaints and has set up a mechanism to receive complaints through the 21 district health centers.

Surveillance is presently carried out by the limited staff assigned to the New York City Health Department and through "contractual arrangements" with recognized institutions and health professionals. To illustrate the latter, the Optometric Center of New York City is assisting in optical review, the M. J. Lewi School of Podiatry is assisting in podiatry review, etc.

3. *Enforcement.*—The Health Department in Medicaid has "teeth" to see that standards are upheld. The Department has the following options which can be exercised depending upon the nature of the case:

- (a) Direct interview with the professional to handle a specific problem.
- (b) Use of professional societies for advice and peer review.
- (c) Temporary suspension.
- (d) Formal administrative hearings with appropriate judgments.
- (e) Elimination from participation in the program.

Is the "Watchdog" System Working?

The "watchdog" system has highlighted certain facts in the delivery of health care in the ghetto areas:

- The general practitioner, as seen through on-site visits, is professionally isolated from his colleagues.
- Dentists, podiatrists, and chiropractors are locating offices in high Medicaid areas.
- Dental offices are generally well-equipped and are geared for efficient production.

The "watchdog" system has identified areas of professional practice requiring appropriate follow-up. Examples follow:

- A small number of pharmacists have been providing smaller quantities of medication than prescribed by the physicians, but nevertheless have billed Medicaid for the total prescribed amount. A small number of pharmacists have altered amounts of prescribed medication, and have billed Medicaid accordingly, but actually dispensed the smaller prescribed quantities.

- A few dentists have not provided services for which they have billed Medicaid. A small number of dentists have not provided dental work of acceptable quality to the patient or the program.
- A small number of podiatrists have prescribed orthopedic shoes in quantities beyond that which can be justified in normal practice. A small number of podiatrists have provided routine radiograph studies of the feet beyond the accepted norm.
- A small number of physicians have provided an unacceptably small amount of time per routine patient visit. A small number of physicians have routinely referred patients to consultant specialists for reasons unacceptable to peer group evaluation.

The above examples are representative, but not all inclusive of the types of cases found by the "watchdog" system. The fact that the system is in operation acts as a constraint upon inappropriate practices in Medicaid and is an important source of encouragement to the majority of professionals who adhere to health care standards of acceptable quality.

APPENDIX E

Selected Carrier Responses to Questions Concerning Determination of "Customary and Prevailing" Charges

APPENDIX E.—SELECTED CARRIER RESPONSES TO QUESTIONS CONCERNING DETERMINATION OF “CUSTOMARY AND PREVAILING” CHARGES

1. Describe the extent and scope of the data on actual customary charges by physicians prevailing in your area and which was in your possession as of the date you initially requested consideration as a Part B carrier for such area.

a. “None”

b. “Two years of claims data on ‘usual and customary’ contract and a State-wide survey conducted by the Medical Society.”

c. “Data from group major medical contracts. These contracts have total outside limits but few inside limits * * *.”

d. “Data on actual customary charges by physicians in our area * * * was very limited. We proposed to use the Relative Value Fee Schedule of the State Medical Association.”

e. “There was no totally validated data on actual customary charges by physicians within the Blue Shield Plan area * * * because Blue Shield was on an indemnity fee schedule * * *.”

f. “* * * history of charges made by physicians to members covered under Blue Shield indemnity fee program.”

g. “data on 117,000 members [of well over 1 million total members] enrolled under usual, customary or reasonable charge concept.”

h. “* * * based upon the principle that local personnel provide the primary base for knowledge as to physicians’ charges. This method relies on local claims personnel’s knowledge * * *.”

i. “* * * we had a general knowledge of the charging practices of physicians in most of the areas we were eventually assigned.”

k. “* * * surveys and relative value studies based on broad surveys were available to us for guides in the absence of sufficient data.”

l. “In 1965 our Research Department queried 9,028 physicians and dentists in regard to the fees each would charge if he were to perform any of a list of specific procedures * * *. As of February 1966 seventy percent of the doctors had responded.”

2. Which of that data were actually used, and to what extent, in your determination of customary and prevailing physician charges in your area as of July 1, 1966?

a. “None.”

b. “The physician fee profile (usual, customary and prevailing), was used on the first level of claims processing.”

c. “30,000 claims submitted under major medical contracts.”

d. “Initially used Relative Value Schedule of State Medical Association.”

e. "Our program was not founded on customary charges. It was founded upon prevailing charges. We extracted from this past data."

f. "All of the data were used."

g. "Checked against a basic guide table which approximated the median coefficient of prevailing charges and then for claims in excess of the median checked against 90th percentile of prevailing charges."

h. "Our local field offices were given extensive instructions directing the exercise of claim judgment. * * * These required immediate application of all information and experience as to customary and prevailing charges."

i. "Did not have sufficient data to produce accurate usual and customary charge profiles but we did feel we had sufficient data to develop a prevailing profile."

k. "Used the individual fees filed by physicians for the Plan's Prevailing Fee Program."

l. "Basic tool was Relative Value Study of State Medical Association. Due to thinness of data and unknown factors about charges for persons of advanced age, determining valid customary charges was not possible initially."

m. "Most fees reported (in the survey of physicians) were used in the determination of customary and prevailing charges."

3. Did you gather any additional data relative to customary physician charges prior to July 1, 1966? If so, please describe the scope and extent of such data and the precise methods employed in securing such data.

a. "No."

b. "No."

c. "Though we did not invite such, various physicians, physician specialty groups and State associations did present us fee surveys, suggested fee schedules, etc., which they used as guidelines * * *. This information was reviewed for comparability with the profile data previously compiled."

d. "Physicians were surveyed, commencing June 17, 1966, and asked to indicate their usual and customary charges."

e. "A survey was performed in February, 1966, to secure the usual fees of physicians."

f. "Individual profiles of charges were developed through the assistance of the State Medical Society."

g. "Accumulated and analyzed physician charges under standard programs."

h. "No."

i. "Clerically accumulated charge data with respect to some of the more common medical and surgical procedures in our Part B area."

k. "Necessary to add to our fee data by a survey of physicians to determine their usual and customary fees for home and office medical visits."

l. "Unofficial reference was made to a 1965 fee survey made by the State Medical Association to check the validity of relative value conversions. The survey resulted in a forty percent response."

m. "No."

4. Describe the additional data you gathered with respect to customary charges by physicians and what methods were used in securing such data subsequent to July 1, 1966.

a. "Gathered data based upon charges reported under the Medicare program."

b. "Used Medicare and Title XIX data in conjunction with Blue Shield Usual and Customary Contract data."

c. "Periodic Statewide profiles and compilations of Medicare charge data."

d. "Physicians profiles developed as result of initial survey adjusted for actual charges to Medicare patients."

e. "Nothing further was secured subsequent to July 1, 1966."

f. "None, beyond individual charge profiles previously developed through assistance of State Medical Society."

g. "Initiated effort to create statistically reliable physician profiles based on claims data derived from all Blue Shield administered programs."

h. "Data as to charges made by each physician has been collected with respect to each Medicare claimant."

i. "Since July 1, 1966, we have been capturing charge data by procedure by physician with respect to all bills submitted under the program."

k. "Since July 1, 1966, there has been no significant gathering of additional data on physicians' customary charges."

l. "Medicare charges were captured by physician, by procedure, from July 1, 1966."

m. "The Research Department gathered Medicare Part B claims data from which a Physician's Charge Profile was established."

5. Do you regularly include *all* physician billings to non-Medicare patients as well as Medicare patients in determining (a) customary and (b) prevailing charges for Medicare? If so, when did you first include all of these non-Medicare physician billings in determining (a) customary and (b) prevailing charges?

a. "Not at present; but will include data from other programs which we administer in the near-future."

b. "Yes—started in April, 1967."

c. "Medicare charges only."

d. "Bills as they are received for services rendered to Medicare patients."

e. "Yes."

f. "Yes."

g. "Since January 1968."

h. "Non-Medicare claims listing not available. Present listing includes all billings to Medicare patients."

i. "Profiles derived solely from charges submitted by Medicare patients."

k. "Since the usual and customary fee information had been received from physicians prior to July 1, 1966, it was not necessary to create usual and customary fees from charges as recorded on individual claim."

l. "No. Blue Shield contracts are generally the basic scheduled fee type."

m. "At this time we use only Medicare information to determine customary and prevailing charges."

APPENDIX F

**Medicare Providers and Medicare Intermediaries as of
February 1, 1969**

APPENDIX F.—MEDICARE PROVIDERS AND MEDICARE INTERMEDIARIES AS OF FEBRUARY 1, 1969

	Number of providers		
	Hospitals	ECF's	HHA's
Blue Cross Association.....	¹ 6, 876	2, 609	1, 693
Aetna Life and Casualty.....	94	327	15
Aetna-Christian Science.....	17	17	-----
The Travelers Insurance Co.....	112	669	19
Mutual of Omaha Insurance Co.....	19	1, 020	10
Kaiser Foundation Health Plan, Inc.....	19	1	3
Hawaii Medical Services Association.....	28	16	5
Community Health Association.....	1	1	-----
The Prudential Insurance Co. of America.....	33	53	36
Nationwide Mutual Insurance Co.....	8	70	24
New York State Department of Health.....	-----	-----	60
Inter County Hospitalization Plan, Inc.....	52	15	7
Cooperativa De Salud De Puerto Rico.....	8	1	-----
Social Security Administration.....	² 639	38	323
Total, United States.....	7, 906	4, 837	2, 195

¹ Included in this total are the 566 emergency hospitals and the 52 emergency hospitals in Canada which BCA services.

² SSA total also includes 402 Federal hospitals.

Note. Because of certain discrepancies in the provider printout to be resolved, 3 hospitals were not included in the compilations. In addition, 11 emergency hospitals have been included on the summary sheet but, because of discrepancies in the printout regarding the servicing plan, have not been included in the individual plan totals.

Blue Cross Association

		Number of providers ³			
	Number	Hospitals	EM	ECF's	HHA's
REGION I					
Connecticut.....	00060	31	1	17	76
Maine.....	00180	62	10	12	23
Massachusetts.....	00200	177	9	96	181
New Hampshire.....	00270	35	-----	6	34
Vermont.....	00270	23	11	1	12
Rhode Island.....	00370	17	-----	9	21
Total.....	-----	345	31	141	347
REGION II					
Delaware.....	00070	10	-----	9	8
New Jersey.....	00280	88	21	34	17
New York:					
Albany.....	00300	29	1	8	3
Buffalo.....	00301	36	9	22	3
Jamestown.....	00302	5	-----	4	1
New York.....	00303	158	18	30	49
Rochester.....	00304	19	1	12	2
Syracuse.....	00305	23	2	18	-----
Utica.....	00306	32	6	19	1
Watertown.....	00307	3	-----	2	-----
Total.....	-----	403	58	158	84

³ "EM"—Emergency Hospital; "ECF"—Extended Care Facility; "HHA"—Home Health Agency.

Blue Cross Association—Continued

		Number of providers			
	Number	Hospitals	EM	ECF's	HHA's
REGION III					
District of Columbia -----	00080	11	4	6	3
Kentucky -----	00160	129	17	32	17
Maryland -----	00080	3	-----	1	2
	00190	55	8	17	27
Pennsylvania:					
Allentown -----	00360	10	-----	7	5
Harrisburg -----	00361	36	4	31	17
Philadelphia -----	00362	43	10	41	17
Pittsburgh -----	00363	107	9	57	28
Wilkes-Barre -----	00364	39	3	19	7
Puerto Rico -----	00470	35	21	2	2
Virginia -----	00080	7	-----	3	2
	00440	3	-----	-----	-----
Richmond -----	00423	69	12	30	1
Roanoke -----	00424	33	3	19	-----
West Virginia:					
Charleston -----	00440	6	1	2	2
Charleston -----	00441	40	6	5	7
Parkersburg -----	00443	8	3	1	3
Wheeling -----	00444	28	3	5	8
Total -----	-----	662	104	278	148
REGION IV					
Alabama -----	00010	118	12	54	2
Florida -----	00090	168	15	37	58
Georgia:					
Atlanta -----	00100	43	8	15	5
Columbus -----	00101	88	15	16	10
Mississippi -----	00230	84	33	9	72
North Carolina -----	00310	152	12	45	15
	00380	-----	-----	-----	1
South Carolina -----	00310	-----	-----	2	-----
	00380	73	12	54	42
Tennessee:					
Chattanooga -----	00390	125	16	39	75
Memphis -----	00392	18	4	10	5
Total -----	-----	869	127	281	285
REGION V					
Illinois:					
Chicago -----	00121	290	20	57	81
Rockford -----	00122	3	-----	2	1
Indiana -----	00130	137	5	75	28
Michigan -----	00210	256	24	30	47
Ohio:					
Canton -----	00331	10	1	3	4
Cincinnati -----	00332	47	5	30	20
Cleveland -----	00333	62	6	46	13
Columbus -----	00334	49	3	6	25
Lima -----	00335	11	2	2	1
Toledo -----	00337	31	1	16	4
Youngstown -----	00338	21	-----	14	5
Wisconsin -----	00450	185	8	145	59
Total -----	-----	1, 102	75	426	288

Blue Cross Association—Continued

	Number	Number of providers			
		Hospitals	EM	ECF's	HHA's
REGION VI					
Iowa:					
Des Moines.....	00140	111	5	31	20
Sioux City.....	00141	38	2	13	6
Kansas:					
Topeka.....	00150	157	-----	58	30
Kansas City, Mo.....	00240	8	-----	3	
Minnesota.....	00220	182	1	74	45
Missouri:					
Kansas City.....	00240	54	2	11	5
St. Louis.....	00241	114	2	37	28
Nebraska.....	00260	106	3	16	3
North Dakota.....	00320	63	11	23	8
South Dakota ¹	00141	61	-----	7	25
Total.....		894	26	273	171
REGION VII					
Arkansas.....	00020	104	4	45	4
Louisiana:					
Baton Rouge.....	00170	112	27	81	39
New Orleans.....	00171	14	9	9	17
New Mexico.....	00290	43	5	15	4
Oklahoma.....	00340	144	14	20	55
Texas.....	00400	516	43	83	38
Total.....		933	102	253	157
REGION VIII					
Colorado.....	00050	89	3	47	20
Idaho.....	00110	49	3	19	9
Montana.....	00250	63	13	21	11
Utah.....	00410	34	6	27	11
Wyoming.....	00460	30	1	9	7
Total.....		265	26	123	58
REGION IX					
Alaska.....	00430	17	1	10	1
Arizona.....	00030	56	11	42	9
California:					
Los Angeles.....	00040	291	18	306	40
Oakland.....	00041	225	11	187	56
Oregon.....	00350	91	2	56	27
Washington:					
Portland, Ore.....	00350	2	-----	2	1
Seattle.....	00430	103	15	73	21
Total.....		785	58	676	155
Grand total.....		6, 258	607	2, 609	1, 693
Canada ²	00180		7		
	00301		5		
	00306		3		
	00210		9		
	00320		11		
	00250		9		
	00430		8		
Total.....			52		

¹ Serviced by Sioux City, Iowa.² These hospitals previously included in totals for each State and grand total.

Aetna Life and Casualty

	Number	Number of providers				
		Hospitals	CS ¹	ECF's	CS ¹	HHA's
REGION I						
Connecticut: Hartford.....	51070	10		2		9
Massachusetts:						
Hartford.....	51070	1	1	1	1	
Worcester.....	51220	14		1		
Total.....		25	1	4	1	9
REGION II						
New York:						
New York.....	51330			1		
Hartford.....	51070	7	1	6	1	
Total.....		7	1	7	1	
REGION III						
Virginia: Newport News..	51490	3				
Pennsylvania: Hartford..	51070		1		1	
Total.....		3	1		1	
REGION IV						
Florida:						
Clearwater.....	51100			130		
Hartford.....	51070		1		1	
Tennessee: Nashville.....	51440	7		6		1
Total.....		7	1	136	1	1
REGION V						
Indiana: Peoria.....	51140			3		
Illinois:						
Peoria.....	51140			112		
Hartford.....	51070		1		1	
Michigan: Hartford.....	51070		1		1	
Ohio: Hartford.....	51070		1		1	
Wisconsin:						
Hartford.....	51070		1		1	
Peoria.....	51140			1		
Total.....			4	116	4	
REGION VI						
Iowa: Peoria.....	51140			5		
Missouri: Hartford.....	51070		2		2	
Minnesota: Peoria.....	51140			1		
Nebraska: Peoria.....	51140			1		
North Dakota: Peoria....	51140			2		
South Dakota: Peoria....	51140			1		
Total.....			2	10	2	

Aetna Life and Casualty—Continued

		Number of providers				
	Number	Hospitals	CS ¹	ECF's	CS ¹	HHA's
REGION VII						
Texas: Hartford.....	51070	-----	1	-----	1	-----
REGION VIII						
Colorado: Hartford.....	51070	-----	1	-----	1	-----
REGION IX						
California:						
Los Angeles.....	51050	17	-----	41	-----	1
Hartford.....	51070	-----	3	-----	3	-----
Nevada: Reno.....	51290	21	-----	13	-----	3
Washington:						
Seattle.....	51500	14	-----	-----	-----	1
Hartford.....	51070	-----	1	-----	1	-----
Oregon: Hartford.....	51070	-----	1	-----	1	-----
Total.....		52	5	54	5	5
Grand total.....		94	17	327	17	15

¹ Christian Science.*The Travelers Insurance Co.*

		Number of providers		
	Number	Hospitals	ECF's	HHA's
REGION I				
Connecticut:				
Hartford.....	50070	8	7	11
New Haven.....	50072	2	128	2
Maine.....	50200	1	10	-----
Massachusetts.....	50221	2	46	-----
New Hampshire and Vermont	50300	1	15	1
Rhode Island.....	50410	-----	16	-----
Total.....	-----	14	222	14
REGION II				
New York:				
Schenectady.....	50330	2	2	-----
New York.....	50331	1	4	-----
Albany.....	50332	1	2	-----
Garden City.....	50333	34	129	-----
Syracuse.....	50334	1	1	-----
Total.....	-----	39	138	-----

The Travelers Insurance Co.—Continued

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION III				
Pennsylvania:				
Erie.....	50390	2	6	-----
Pittsburgh.....	50391	-----	18	-----
Reading.....	50392	1	26	-----
Philadelphia.....	50393	-----	14	1
Total.....	-----	3	64	1
REGION IV				
Florida:				
Jacksonville.....	50100	3	-----	-----
Miami.....	50101	2	-----	1
Tampa.....	50102	2	-----	-----
Georgia.....	50110	13	59	-----
Total.....	-----	20	59	1
REGION V				
Michigan:				
Detroit.....	50230	7	67	-----
Grand Rapids.....	50231	3	40	-----
Total.....	-----	10	107	-----
REGION VI				
Minnesota:				
Rochester.....	50240	3	1	2
Minneapolis.....	50241	-----	60	-----
Total.....	-----	3	61	2
REGION VII				
New Mexico.....	50320	-----	8	-----
Total.....	-----	-----	8	-----
REGION IX				
California:				
Long Beach.....	50050	5	-----	-----
Los Angeles.....	50051	14	9	1
Pomona.....	50052	2	-----	-----
San Francisco.....	50053	2	1	-----
Total.....	-----	23	10	1
Grand total.....	-----	112	669	19

Mutual of Omaha

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION III				
District of Columbia -----	52280	3	1	-----
Kentucky -----	52280	-----	27	-----
Maryland -----	52280	3	37	1
Virginia -----	52280	1	2	-----
Virgin Islands -----	52280	5	-----	1
West Virginia -----	52280	-----	13	1
Total -----	-----	12	80	3
REGION IV				
Alabama -----	52280	2	42	1
Mississippi -----	52280	-----	18	-----
Total -----	-----	2	60	1
REGION V				
Wisconsin -----	52280	-----	39	-----
REGION VI				
Iowa -----	52280	-----	37	-----
Kansas -----	52280	-----	-----	-----
Minnesota -----	52280	-----	4	-----
Missouri -----	52280	-----	26	-----
Nebraska -----	52280	4	18	2
South Dakota -----	52280	-----	10	-----
Total -----	-----	4	95	2
REGION VII				
Oklahoma -----	52280	-----	23	1
Texas -----	52280	-----	196	-----
Total -----	-----	-----	219	2
REGION VIII				
Colorado -----	52280	-----	42	-----
Idaho -----	52280	-----	20	-----
Montana -----	52280	-----	11	1
Wyoming -----	52280	-----	1	-----
Total -----	-----	-----	74	1
REGION IX				
California -----	52280	1	338	1
Oregon -----	52280	-----	32	-----
Washington -----	52280	-----	83	-----
Total -----	-----	1	453	1
Grand total -----	-----	19	1, 020	10

Kaiser Foundation Health Plan, Inc.

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION IX				
California.....	19050	17	1	2
Hawaii.....	19050	1	-----	-----
Oregon.....	19050	1	-----	1
Total.....		19	1	3

Hawaii Medical Services Association

		Number of providers			
		Number	Hospitals	ECF's	HHA's
REGION IX					
Hawaii.....	17120	27	15	4	
Guam.....	17120	1	1	1	
Total.....		28	16	5	

Community Health Association

		Number of providers		
	Number	Hospitals	ECF's	HHA's
REGION V				
Michigan-----	21230	1	1	-----

The Prudential Insurance Co. of America

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION II				
New Jersey-----	53310	33	53	36

Nationwide Mutual Insurance Co.

		Number of providers		
	Number	Hospitals	ECF's	HHA's
REGION V				
Ohio.....	56360	8	70	24

New York State Department of Health

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION II				
New York.....	20330			60

Inter County Hospitalization Plan, Inc.

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION III				
Pennsylvania-----	18390	52	15	7

Cooperativa de Salud de Puerto Rico

	Number	Number of providers		
		Hospitals	ECF's	HHA's
REGION III				
Puerto Rico-----	22400	8	1	-----

Social Security Administration

	Number	Number of providers			
		Hospitals	Federal	ECF's	HHA's
REGION I					
Connecticut-----	99990	-----	4	-----	-----
Maine-----	99990	-----	3	-----	-----
Massachusetts-----	99990	-----	10	-----	-----
New Hampshire-----	99990	-----	2	-----	-----
Rhode Island-----	99990	5	2	1	-----
Vermont-----	99990	-----	1	-----	-----
Total-----		5	22	1	-----

REGION II					
Delaware.....	99990		2		
New Jersey.....	99990		5	1	
New York.....	99990	54	16	7	15
Total.....		54	23	8	15

REGION III					
District of Columbia.....	99990	1	2		
Kentucky.....	99990		6		
Maryland.....	99990		11		
Pennsylvania.....	99990	4	13		46
Puerto Rico.....	99990	68	1	2	
Virginia.....	99990	1	11		129
West Virginia.....	99990	1	5		1
Total.....		75	49	2	176

Social Security Administration—Continued

		Number of providers			
	Number	Hospitals	Federal	ECF's	HHA's
REGION IV					
Alabama.....	99990		9		42
Florida.....	99990	2	13	1	
Georgia.....	99990	5	14		
Mississippi.....	99990	2	6		
North Carolina.....	99990		9	1	1
South Carolina.....	99990	1	7		
Tennessee.....	99990		7		
Total.....		10	65	2	43
REGION V					
Illinois.....	99990	3	9	4	
Indiana.....	99990	1	6	1	1
Michigan.....	99990	4	11	1	
Ohio.....	99990	29	8	2	1
Wisconsin.....	99990	3	3	1	1
Total.....		40	37	9	3
REGION VI					
Iowa.....	99990		3		
Kansas.....	99990	2	8	2	
Minnesota.....	99990	13	2	2	
Missouri.....	99990	2	8	3	1
Nebraska.....	99990		5		
North Dakota.....	99990		3		
South Dakota.....	99990	1	5		
Total.....		18	34	7	1
REGION VII					
Arkansas.....	99990	1	5		69
Louisiana.....	99990		8		14
New Mexico.....	99990	1	11		
Oklahoma.....	99990		12		
Texas.....	99990	2	32	1	
Total.....		4	68	1	83
REGION VIII					
Colorado.....	99990		6		
Idaho.....	99990		2		
Montana.....	99990	1	7		
Utah.....	99990	2	1		
Wyoming.....	99990		3		
Total.....		3	19		
REGION IX					
Alaska.....	99990	4	12		
Arizona.....	99990	2	17	2	
California.....	99990	17	35	5	1
Hawaii.....	99990		1	1	
Nevada.....	99990		4		
Oregon.....	99990		3		
Washington.....	99990	5	13		1
Total.....		28	85	8	2
Grand total		237	402	38	323

APPENDIX G

Intermediary Operations: Selected Workload and Cost Data,
January-March 1969

APPENDIX G.—INTERMEDIARY OPERATIONS: SELECTED WORKLOAD AND COST DATA, JANUARY—MARCH 1969

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Intermediary	Workload distributions					Workload performance indicators					Processing time, average number of days between date forwarded to interest and date approved for payment			Bills reviewed by SSA	
	Percent of receipts by type of bill					Percent of bills pending over 30 days					In-patient bills			Number	
	Percent of receipts by type of bill					Percent of bills pending over 30 days					In-patient bills			Number	
	Percent of national receipts	In-patient hospital	Out-patient hospital	ECF	HHA	Ratio of clearance to receipts	Weeks work on hand	Percent of bills pending over 30 days	Percent additional development		In-patient bills	Out-patient bills		Percent returned because of error	
Total, all regions--	100.0	42.1	41.0	7.8	8.3	99.0	1.2	12.9	9.0		12.1	25.4		2,650,353	5.2
Los Angeles, Calif., B/C--	5.5	38.3	39.0	10.8	10.2	102.0	1.0	21.0	8.1		12.8	28.0		124,361	5.6
Chicago, Ill., B/C--	5.0	45.8	46.6	1.2	6.3	103.3	2.2	20.7	12.8		23.7	41.6		136,877	5.7
New York, N.Y., B/C--	4.9	36.3	56.8	1.1	5.7	96.1	1.4	9.2	13.0		7.2	20.4		147,039	2.6
Oakland, Calif., B/C--	4.3	31.1	51.6	6.6	10.3	85.1	1.4	24.2	7.3		15.2	26.2		112,009	9.4
Michigan, B/C-----	3.8	34.8	59.0	1.2	4.8	107.8	1.9	9.2	6.1		13.2	60.4		100,948	1.9
Texas, B/C-----	3.8	63.2	26.6	2.9	7.2	100.1	1.1	19.3	7.9		17.9	25.8		135,251	8.5
Florida, B/C-----	3.8	47.0	42.2	2.3	8.2	101.0	.9	5.0	6.2		8.7	14.6		112,030	3.1
Massachusetts, B/C--	3.5	25.9	52.5	5.7	15.8	96.4	.9	8.2	3.7		11.4	24.3		112,596	5.9
Pittsburgh, Pa., B/C--	2.7	32.4	55.2	4.6	7.5	99.6	.7	9.9	11.8		8.4	15.5		69,430	2.0
Indiana, B/C-----	2.4	40.7	48.6	6.3	4.2	93.8	1.5	43.7	8.7		9.3	39.3		63,365	2.4
St. Louis, Mo, B/C--	2.2	43.6	44.3	3.2	8.7	96.7	.9	9.4	11.9		14.7	19.2		52,927	11.2
Wisconsin, B/C-----	2.2	45.8	37.7	4.6	11.3	99.7	1.0	12.4	12.7		10.0	19.4		61,276	3.3
Minnesota, B/C-----	2.0	51.5	35.3	4.2	7.9	101.5	.9	8.3	15.9		8.7	26.4		39,104	1.6
New Jersey, B/C-----	1.8	47.0	41.3	6.7	4.9	101.5	.5	4.3	14.1		9.7	25.7		47,328	4.7
North Carolina, B/C--	1.7	52.1	41.3	4.4	1.7	105.4	1.4	24.3	11.8		24.0	35.9		35,624	4.7
Pennsylvania, Inter-county-----	1.7	29.1	68.0	1.3	1.6	102.4	3.8	4.4	6.1		7.5	46.1		45,311	4.3
Social Security Administration-----	1.6	50.5	22.6	2.9	17.1	95.4	2.5	14.9	2.3		38.4	30.2		25,032	7.3
Kentucky, B/C-----	1.6	51.2	38.3	2.5	7.4	97.3	.8	9.6	10.7		10.4	17.9		42,190	1.5
New Jersey, Prudential-----	1.3	24.6	25.8	18.6	30.5	97.9	.5	1.1	11.4		6.4	11.2		29,323	2.9
Des Moines, Iowa, B/C--	1.3	56.1	30.7	4.2	7.9	96.7	.9	8.9	13.1		9.5	20.7		28,606	5.6

APPENDIX G.—INTERMEDIARY OPERATIONS: SELECTED WORKLOAD AND COST DATA, JANUARY-MARCH 1969—Continued

Intermediary	Workload distributions				Workload performance indicators				Processing time, average number of days between date forward to interest and date approved and date payment			Bills reviewed by SSA	
	Percent of national receipts	Percent of receipts by type of bill			Ratio of clearance to receipts	Weeks work on hand	Percent of bills pending over 30 days	Percent request additional development	In-patient bills	Out-patient bills	Number	Percent returned because of error	
		In-patient hospital	Out-patient hospital	HHA									ECF
Cleveland, Ohio, B/C-----	1.3	37.2	50.9	7.8	4.1	97.4	1.0	17.8	9.0	11.3	29.7	38,294	2.6
Seattle, Wash., B/C-----	1.2	48.1	32.9	8.4	10.3	94.7	1.7	10.6	12.2	11.7	42.7	28,343	5.8
Chattanooga, Tenn., B/C-----	1.2	54.5	33.1	8.1	3.8	99.9	.5	15.1	8.4	8.6	15.0	34,654	1.8
Topeka, Kans., B/C-----	1.1	58.8	31.2	4.6	3.8	100.5	.9	23.3	17.6	13.8	15.9	28,547	4.8
Colorado, B/C-----	1.1	49.0	38.1	5.1	7.1	97.6	1.6	3.3	9.3	15.8	36.0	30,398	4.4
Oklahoma, B/C-----	1.1	63.3	23.8	2.9	10.0	76.4	.8	22.6	3.0	11.9	21.2	16,580	7.1
Alabama, B/C-----	1.1	62.7	31.8	3.3	2.1	101.1	.4	5.1	4.8	8.2	15.8	26,783	6.1
Cincinnati, Ohio, B/C-----	1.1	34.4	48.7	5.5	10.8	100.5	.7	17.7	4.6	15.6	35.3	35,486	4.6
Baltimore, Md., B/C-----	1.0	35.5	56.9	2.9	4.6	97.7	.9	5.5	3.7	10.9	22.1	38,222	10.9
Columbus, Ga., B/C-----	1.0	52.9	38.7	3.1	4.8	99.4	.6	2.7	8.8	9.8	20.9	24,696	3.7
Oregon, B/C-----	.9	49.8	30.6	8.3	11.1	98.6	1.0	.5	9.0	9.2	17.5	21,084	2.7
Connecticut, B/C-----	.9	38.1	39.6	1.6	19.2	103.0	.6	9.0	4.5	6.8	14.3	24,218	4.3
Baton Rouge, La., B/C-----	.9	54.6	36.1	3.2	4.4	101.1	1.9	12.2	4.7	12.6	19.6	19,167	3.3
Richmond, Va., B/C-----	.8	54.7	37.2	7.0	1.0	96.2	.5	1.9	6.8	12.2	23.2	22,998	9.4
Harrisburg, Pa., B/C-----	.8	35.8	48.0	4.9	11.0	98.2	1.2	6.0	10.0	7.0	25.7	25,489	1.9
New York, Travelers-----	.8	33.8	10.3	46.9	0	98.3	.2	6.3	5.1	6.6	22.1	12,458	31.3
Arizona, B/C-----	.8	42.8	37.8	6.9	11.9	99.6	.4	0	6.9	8.8	16.0	18,821	2.0
Philadelphia, Pa., B/C-----	.8	27.3	51.1	8.3	13.1	97.9	.9	10.6	12.5	5.8	23.4	21,785	3.5
Arkansas, B/C-----	.8	68.3	26.0	4.1	1.3	98.8	.2	9.1	7.1	7.3	11.4	15,207	6.3
Mississippi, B/C-----	.8	73.4	18.3	2.1	4.8	97.7	.7	11.9	13.6	14.1	23.2	15,608	3.7

South Carolina, B/C-----	.8	51.0	31.1	8.6	7.7	102.1	.7	21.2	8.0	12.4	17.6	18,640	9.3
Columbus, Ohio, B/C-----	.8	45.6	46.2	7.7	7.2	95.4	1.5	23.5	6.9	9.2	20.7	22,608	2.3
Buffalo, N. Y., B/C-----	.8	36.1	54.3	5.4	4.0	101.4	.8	9.6	7.2	9.3	28.2	35,681	9.7
Kansas City, Mo., B/C-----	.7	51.8	37.5	2.7	7.2	96.7	1.4	3.5	14.4	10.0	31.2	27,269	3.9
Rhode Island, B/C-----	.6	25.4	58.9	1.3	14.5	90.4	2.5	4.4	11.5	9.0	24.9	25,146	12.0
Wilkes-Barre, Pa., B/C-----	.6	40.2	41.3	2.7	15.8	97.9	.5	.3	9.1	5.1	14.3	16,944	2.7
Atlanta, Ga., B/C-----	.6	39.5	45.5	4.9	9.7	111.8	1.0	15.8	6.8	8.9	43.9	19,208	4.1
Nebraska, B/C-----	.6	64.9	30.9	3.1	.8	102.3	.5	1.1	15.3	3.6	10.8	14,310	3.1
Syracuse, N. Y., B/C-----	.6	38.0	59.4	2.0	.5	98.6	1.1	24.3	6.9	8.9	17.9	17,436	3.6
Maine, B/C-----	.6	38.6	47.9	2.3	11.1	101.0	.3	5.2	5.4	8.7	9.5	19,849	1.8
Albany, N. Y., B/C-----	.6	43.2	49.8	1.6	5.2	104.8	2.3	10.9	7.8	15.2	41.3	16,679	2.3
Rochester, N. Y., B/C-----	.5	27.1	56.9	6.0	8.4	97.8	.5	31.5	6.2	5.1	32.7	14,075	4.6
California, Mutual-----	.5	.7	4.5	91.0	.5	92.8	3.4	14.6	15.9	(1)	(1)	(1)	(1)
New Orleans, La., B/C-----	.5	32.9	44.6	4.1	15.6	102.4	.7	14.9	7.4	5.5	14.9	16,222	5.8
Toledo, Ohio, B/C-----	.5	50.4	38.2	5.6	5.2	99.9	1.1	1.5	6.2	8.1	12.7	11,964	2.4
Charleston, W. Va., B/C-----	.4	44.3	49.7	2.7	3.1	98.2	.3	.8	2.9	11.6	24.6	15,504	2.1
Ohio, Nationwide-----	.4	20.4	26.6	27.4	25.3	97.9	.5	8.4	4.4	9.0	12.9	12,681	5.7
Florida, Aetna-----	.4	0	8.7	89.0	0	97.2	.8	1.9	12.2	(2)	21.8	1,217	4.9
Utah, B/C-----	.4	41.5	45.2	6.4	6.5	97.3	1.8	3.4	11.0	10.1	43.3	9,425	7.6
New Hampshire, B/C-----	.4	35.3	42.8	3.5	18.2	103.5	1.4	29.5	10.5	13.9	7.2	19,166	2.6
Memphis, Tenn., B/C-----	.4	41.0	49.1	3.8	4.8	100.8	.5	11.2	8.0	7.4	26.6	14,101	2.8
Connecticut, Travelers-----	.4	15.2	12.8	53.5	15.8	97.1	.3	21.3	3.2	10.4	25.2	9,235	26.9
Youngstown, Ohio, B/C-----	.4	48.0	35.0	6.7	9.3	98.8	.7	16.9	10.9	8.6	24.7	11,926	3.4
Utica, N. Y., B/C-----	.4	40.6	50.6	5.6	3.0	100.5	1.2	3.1	4.4	6.8	11.5	11,920	2.3
New Mexico, B/C-----	.4	48.0	35.3	3.8	12.6	108.0	1.0	4.9	6.8	14.7	20.4	9,847	8.6
Montana, B/C-----	.4	59.2	28.3	2.6	7.8	98.7	.3	6.3	5.9	7.0	12.4	9,429	4.4
Idaho, B/C-----	.4	41.0	45.5	3.1	10.2	101.9	.6	12.5	5.1	7.8	14.2	11,483	2.8
Sioux City, Iowa, B/C-----	.3	57.8	32.9	3.0	5.8	99.6	.6	5.9	7.8	7.4	17.0	17,975	3.4
Wheeling, W. Va., B/C-----	.3	46.7	40.5	2.2	10.5	99.5	.2	0	10.3	6.7	6.9	9,641	1.5
New York, Department of Health-----	.3	0	0	0	99.9	106.8	1.9	25.4	5.2	(2)	(2)	9,059	2.3

See footnotes at end of table, p. 279.

APPENDIX G.—INTERMEDIARY OPERATIONS: SELECTED WORKLOAD AND COST DATA, JANUARY-MARCH 1969—Continued

Intermediary	Workload distributions				Workload performance indicators					Processing time, average number of days between date forward to interest and date approved for payment		Bills reviewed by SSA	
	Percent of national receipts	Percent of receipts by type of bill				Ratio of clearance to receipts	Weeks work on hand	Percent of bills pending over 30 days	Percent request additional development	In-patient bills	Out-patient bills	Number	Percent returned because of error
		In-patient hospital	Out-patient hospital	ECF	HHA								
Massachusetts, Aetna-----	.3	51.7	47.9	.1	0	101.2	.2	4.2	4.3	7.3	10.3	9,240	1.4
South Dakota, B/C-----	.3	65.4	24.2	1.9	8.2	101.4	.5	6.4	8.5	(1)	(1)	(1)	(1)
Illinois, Aetna-----	.3	0	4.8	93.4	0	99.3	.2	7.3	5.2	(2)	18.6	668	2.5
Texas, Mutual-----	.3	(3)	2.7	78.3	17.0	94.5	3.6	18.1	15.0	(1)	(1)	(1)	(1)
North Dakota, B/C-----	.3	73.9	19.9	3.1	2.9	96.4	1.1	3.0	12.4	6.1	18.0	4,922	5.0
Roanoke, Va., B/C-----	.3	57.8	30.7	9.7	0	100.3	.6	10.6	8.0	13.3	14.8	7,868	4.9
Michigan, Travelers-----	.3	15.6	6.5	71.3	0	102.4	3.3	35.8	6.6	8.0	22.6	4,466	21.8
District of Columbia, B/C-----	.3	42.2	46.8	1.4	7.5	105.0	1.1	8.3	11.2	9.2	12.9	12,197	6.4
Delaware, B/C-----	.3	25.5	49.0	5.7	15.6	96.7	.7	12.2	9.5	18.6	13.5	8,917	4.1
Vermont, B/C-----	.3	37.7	48.5	.3	13.3	102.7	1.8	30.2	13.8	(1)	(1)	(1)	(1)
Hawaii, Hawaii Medical-----	.2	38.7	41.5	10.9	6.1	99.8	1.0	20.5	7.0	12.6	23.1	7,172	4.5
California, Aetna-----	.2	51.0	28.6	16.0	1.3	99.4	.8	0	8.8	7.6	18.2	3,491	1.9
Allentown Pa., B/C-----	.2	30.5	45.8	4.3	17.9	99.0	.3	2.1	2.4	2.6	7.7	8,557	2.3
California, Travelers-----	.2	42.2	20.7	33.8	2.5	100.8	.4	5.2	4.3	6.5	14.3	4,874	12.4
Canton, Ohio, B/C-----	.2	41.1	44.3	3.0	10.3	96.2	1.2	8.4	6.2	11.3	27.5	7,851	0.8
Puerto Rico, B/C-----	.2	58.8	20.4	.4	20.4	94.7	1.6	45.2	5.4	25.3	92.3	4,073	17.9
Nevada, Aetna-----	.2	42.5	37.4	7.6	8.5	98.6	.4	3.3	9.5	6.6	19.4	2,818	1.2
Massachusetts, Travelers-----	.2	8.9	15.8	71.4	0	99.9	.2	0	3.6	5.7	15.3	5,233	16.0
Pennsylvania, Travelers-----	.2	6.9	8.3	78.4	1.5	100.0	.4	30.4	5.1	3.6	15.6	2,551	15.2
Lima, Ohio, B/C-----	.2	52.2	42.0	2.4	3.4	101.2	.5	8.1	7.3	5.9	11.6	4,187	3.0

Maryland, Mutual-----	.2	24.9	27.9	44.1	.3	94.6	3.2	12.2	8.4	(1)		(1)	4,495	3.7
Wyoming, B/C-----	.2	53.3	33.9	4.7	7.9	100.1	1.0	7.9	10.6	9.0	16.0	(1)	20,044	7.1
Connecticut, Aetna-----	.2	56.7	27.3	.3	15.6	100.2	.3	0	3.9	6.4	12.9	(1)	1,889	1.2
Washington, Aetna-----	.1	75.6	24.0	0	.2	98.3	.5	9.1	9.5	9.2	13.8	(1)		(1)
Kansas City, Kans., B/C-----	.1	49.2	40.2	2.7	6.9	100.8	1.6	2.7	15.6	(1)				
California, Kaiser-----	.1	76.6	3.6	5.0	14.7	100.1	.1	31.3	3.7	11.7	8.8		2,615	6.6
Georgia, Travelers-----	.1	43.9	22.4	33.1	0	96.8	.7	12.6	6.5	12.9	18.0	(1)	3,065	31.8
Washington, Mutual-----	.1	0	8.7	91.0	0	86.6	3.9	13.0	16.9	(1)			(1)	(1)
District of Columbia, Mutual-----	.1	27.5	65.5	5.6	.2	70.9	4.0	11.1	12.6	(4)		(4)		(4)
Nebraska, Mutual-----	.1	43.0	13.2	22.9	20.8	93.3	2.8	11.2	5.8	19.4	29.4		22,749	7.5
Tennessee, Aetna-----	.1	45.7	41.2	8.5	4.6	100.5	.2	6.6	5.8	9.6	10.1		2,159	1.1
Rockford, Ill., B/C-----	.1	36.7	43.4	6.9	13.0	101.9	1.3	19.3	6.2	11.8	22.6		3,720	4.6
Minnesota, Travelers-----	.1	45.8	6.3	46.0	1.9	99.9	.1	20.3	10.8	2.5	30.7		3,142	19.2
Parkersburg, W. Va., B/C-----	.1	55.6	31.7	.6	12.1	101.4	1.1	7.8	4.6	7.8	13.8		3,396	2.9
Virginia--District of Columbia, B/C-----	.1	42.7	27.5	7.2	19.7	106.4	1.4	13.0	9.7	(4)		(4)		(4)
Bluefield, W. Va., B/C-----	.1	42.9	57.1	0	0	96.4	.6	.8	8.2	15.1	18.7		5,188	1.5
Jamestown, N.Y., B/C-----	.1	50.9	36.9	8.4	3.9	102.1	1.7	8.1	11.0	7.7	13.6		1,879	2.2
Puerto Rico, Coop-----	.1	55.2	44.1	.7	0	100.2	1.8	52.4	9.2	20.7	32.0		2,723	3.7
Kentucky, Mutual-----	.1	0	.5	92.6	0	83.4	3.4	14.1	14.5	(4)		(4)		(4)
Virginia, Aetna-----	.1	52.9	47.1	0	0	100.4	(5)	0	34.5	5.0	10.7		602	.8
Alabama, Mutual-----	.1	16.7	2.5	65.9	14.8	97.3	2.8	14.6	13.4	(4)		(4)		(4)
Watertown, N.Y., B/C-----	.1	45.9	50.7	1.9	0	102.1	.4	7.1	15.8	6.1	7.8		1,931	5.6
Iowa, Mutual-----	.1	0	1.0	98.7	0	92.4	3.5	12.2	18.4	(4)		(4)		(4)
Maine, Travelers-----	(3)	14.4	6.6	79.0	0	100.0	0	0	0	6.8	15.0		907	14.8
Maryland--District of Columbia, B/C-----	(2)	30.8	60.7	1.8	4.3	105.6	1.9	5.2	11.6	(4)		(4)		(4)
Oregon, Mutual-----	(3)	0	4.3	95.2	0	89.9	4.0	13.2	15.6	(4)		(4)		(4)
Missouri, Mutual-----	(2)	0	.1	99.5	0	92.5	3.5	16.4	13.5	(4)		(4)		(4)
Colorado, Mutual-----	(2)	0	12.8	86.2	0	93.0	3.8	15.3	15.6	(4)		(4)		(4)
New Hampshire, Travelers-----	(2)	14.6	39.5	45.9	0	100.4	.5	0	2.2	10.1	10.6		883	5.0
Bluefield, Virginia, B/C-----	(3)	39.9	59.8	0	0	92.1	2.3	0	4.4	(4)		(4)		(4)

See footnotes at end of table, p. 279.

APPENDIX G.—INTERMEDIARY OPERATIONS: SELECTED WORKLOAD AND COST DATA, JANUARY-MARCH 1969—Continued

Intermediary	Workload distributions				Workload performance indicators					Processing time, average number of days between date forward to interest and date payment for payment		Bills reviewed by SSA	
	Percent of receipts by type of bill				Ratio of clearance work on hand	Percent of bills pending over 30 days	Percent request additional development	In-patient bills	Out-patient bills	Percent returned because of error	Number		
	Percent of national receipts	In-patient hospital	Out-patient hospital	ECF	HHA								
Rhode Island, Travelers-----	(3)	0	0	100.0	0	0	0	6.8	(6)	(4)	162	24.1	(4)
Oklahoma, Mutual-----	(3)	0	6.0	94.0	0	0	15.8	19.7	(4)	(4)	(4)	(4)	(4)
Mississippi, Mutual-----	(3)	0	0	100.0	0	0	14.7	16.3	(4)	(4)	(4)	(4)	(4)
Wisconsin, Mutual-----	(3)	0	3.0	92.9	0	0	17.6	16.8	(4)	(4)	(4)	(4)	(4)
Florida, Travelers-----	(3)	59.5	16.9	2.1	21.5	1.3	6.4	16.7	13.1	36.4	1,101	21.1	(4)
Portland, Wash., B/C-----	(3)	57.5	29.5	4.3	8.8	1.4	1.5	8.0	(4)	(4)	(4)	(4)	(4)
Virginia, Mutual-----	(3)	35.1	25.7	37.5	1.1	3.7	14.4	10.7	(4)	(4)	(4)	(4)	(4)
New York, Aetna-----	(3)	27.7	2.5	69.7	0	(3)	0	5.5	(4)	(4)	(4)	(4)	(4)
Idaho, Mutual-----	(3)	0	2.2	96.0	0	3.8	12.9	20.1	(4)	(4)	(4)	(4)	(4)
Oregon, Kaiser-----	(3)	63.2	1.8	11.9	23.1	.1	33.3	3.9	(4)	(4)	(4)	(4)	(4)
Chattanooga, Ga., B/C-----	(3)	49.1	29.3	21.5	0	.3	13.2	11.6	(4)	(4)	(4)	(4)	(4)
Montana, Mutual-----	(3)	0	6.9	82.3	10.3	4.1	20.9	15.7	(4)	(4)	(4)	(4)	(4)
Alaska, B/C-----	(3)	74.0	12.9	6.7	6.3	.4	25.9	10.2	(4)	(4)	(4)	(4)	(4)
CS, Aetna-----	(3)	80.9	0	10.1	0	0	0	8.8	(4)	(4)	(4)	(4)	(4)
West Virginia, Mutual-----	(3)	0	.7	98.2	0	3.6	27.6	16.2	(4)	(4)	(4)	(4)	(4)
New Mexico, Travelers-----	(3)	0	0	100.0	0	0	0	4.2	(6)	(6)	112	36.6	(4)
Virgin Islands, Mutual-----	(3)	43.3	17.8	0	38.6	5.5	24.3	5.1	(4)	(4)	(4)	(4)	(4)
Vermont, Travelers-----	(3)	0	0	99.9	0	.3	0	4.6	(4)	(4)	(4)	(4)	(4)
South Dakota, Mutual-----	(3)	0	1.4	98.3	0	3.1	26.6	12.3	(4)	(4)	(4)	(4)	(4)
Iowa, Aetna-----	(3)	0	5.7	94.3	0	3.0	9.1	20.4	(4)	(4)	(4)	(4)	(4)

Michigan, Commissioner, Health-----	(3)	81.6	0	19.2	0	115.6	2.1	92.3	4.9	18.3	52.8	341	5.9
Minnesota, Mutual-----	(3)	0	0	100.0	0	70.2	6.7	22.3	36.6	(1)	(1)	(1)	(1)
Indiana, Aetna-----	(3)	0	4.1	95.9	0	36.2	10.3	48.0	15.5	(7)	(7)	(7)	(7)
Hawaii, Kaiser-----	(3)	96.3	0	0	0	100.5	.2	33.3	2.6	(1)	(1)	(1)	(1)
North Dakota, Aetna-----	(3)	0	7.1	92.9	0	86.5	3.4	28.7	24.0	(7)	(7)	(7)	(7)
Wisconsin, Aetna-----	(3)	0	7.8	92.2	0	79.2	4.3	18.8	19.7	(7)	(7)	(7)	(7)
Nebraska, Aetna-----	(3)	0	0	100.0	0	94.2	2.8	50.0	27.4	(7)	(7)	(7)	(7)
Minnesota, Aetna-----	(3)	0	0	100.0	0	80.6	32.8	28.6	24.2	(7)	(7)	(7)	(7)
South Dakota, Aetna-----	(3)	0	0	100.0	0	69.4	7.3	38.2	16.7	(7)	(7)	(7)	(7)
Kansas, Mutual-----	(3)	0	0	100.0	0	73.3	17.4	46.4	52.2	(1)	(1)	(1)	(1)

¹ Individual State data are not available. Data included in the State where the home office is located. (See enclosure.)

² This intermediary office does not process inpatient or outpatient hospital bills. Bills shown in the outpatient bill column represent outpatient ECF bills.

³ Less than 0.05 percent.

⁴ Individual State data are not available. Data included in the State where the home office is located

⁵ Less than 0.05 weeks work on hand.

⁶ This intermediary office does not process inpatient or outpatient hospital bills.

⁷ Individual State data are not available. Data included in Aetna at Peoria, Ill.

APPENDIX H

Various Measures of Carrier Performance in Medicare

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APPENDIX H.—VARIOUS MEASURES OF CARRIER PERFORMANCE IN MEDICARE

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., December 6, 1968.

Mr. THOMAS VAIL,
*Chief Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.*

DEAR TOM: This is in further reply to your letter requesting information about the performance of Medicare carriers. Enclosed are responses to your remaining questions with the exception of questions 5(g)¹ and 6. We are completing the current tabulations which are essential to answering these questions and will transmit the information to you shortly. In addition, we are gathering data required to answer the questions raised in your letter of October 15.

As you requested, we have, wherever possible, prepared numerical rankings with respect to specific indices of carrier performance. Although these are the principal statistically measurable indications of carrier performance available to us at this time, there are, of course, a great variety of qualitative considerations which such rankings do not adequately reflect such as: the application of the requirements of the law and regulations to the processing of Medicare claims, including effectiveness in the application of criteria for the determination of reasonable charges; carrier responsiveness to inquiries and to other needs for service and help, as indicated by beneficiaries and our field organization; and the establishment of effective relationships with the medical community.

Given the newness of the program and the varying factors that affected the carriers' ability to respond to a great variety of different situations, we do not look just to past performance in making comparative judgments among carriers. Indications of present performance and, indeed, of the acquisition of capability for improved performance have been as significant in some cases as past data. One other caution needs to be expressed concerning comparisons. Close comparisons based on statistical indices are not only subject to the vagaries of the start-up period, but may be affected by demographic, economic and other factors. We have found it necessary to assess carefully the ameliorating or aggravating circumstances which, for a particular carrier, may make a particular statistical comparison or ranking with other carriers less meaningful than a general operational assessment.

In sending you this material at this time, I should like to observe that frequent staff contact with carriers, together with current operating data over the past 3 to 6 months, indicate a continuing improvement in overall carrier performance that is encouraging and that is not always readily apparent from the latest performance data that is being systematically collected and periodically tabulated.

Sincerely yours,

ROBERT M. BALL,
Commissioner of Social Security.

¹ Subsequently received; appears at page 302.

5. Please rank each of the carriers on the basis of the following factors, giving the requested information for each of them.

The following pages give a detailed response to each of the 16 sub-parts of this question. The carriers are listed by individual service area (when data are available for such areas), arranged alphabetically by State. Where data are available only for the combined operations of multi-State carriers, this fact is indicated in the table and the combined data are presented at the end of the table.

Because some carriers have service areas which encompass only parts of States, it may be desirable to identify the specific geographic areas served. This can be done by referring back to the response to question 1, previously furnished.

As is evident from the textual explanation accompanying the answers to the sub-parts of this question, the ranking of the carriers in connection with the data requested is a function of a large number of variables which affect the performance of the carrier—some factors are unique and apply only with respect to one carrier. The ranking shown may not indicate superior or deficient performance, but the presence of one or more factors outside the carrier's control which may be present regardless of which carrier might have served in the area. Moreover, there is no known alternative index of performance which would show how the given carrier's performance compares with potential substitute carriers.

A non-mathematical composite view of performance has been used in the past to judge how well each carrier is meeting its contractual obligations and we are now developing a master index of carrier performance.

*5. (a) Please rank each of the carriers on the basis of * * * average processing time from receipt of claim to certification of payment for the most recent quarter for which data is available.*

Enclosed is a table listing, for each carrier service area, the processing time in calendar days for paid bills at the 25th, 50th, and 75th percentile. Data are presented in terms of bills (rather than claims, as requested) because a claim may or may not include more than one bill—and each bill may be processed separately and with different processing times due to differences in type of services for which reimbursement is claimed, degree of completeness of information, and other factors affecting the length of time it takes from the date of receipt to the date of certification for payment. Carriers submit to SSA summaries of the bills they certify for payment, and these payment records constitute the basis for the rankings.

Rankings are according to median processing time, in calendar days. The median processing time was used instead of the mean time because the latter may be strongly affected by even a few extreme values.

Carrier bill processing time is, in part, a function of the extent to which the carrier has computerized its operations and the sophistication of the computer equipment. Another factor is the availability to the carrier of trained personnel to process the bills received in relation to the work volume. Still another factor is that relatively longer processing times may reflect a more thorough claims review process.

Average Processing Time from Carrier's Receipt of Bill to Certification for Payment, April-June 1968, by State and Carrier Service Area

State	Carrier	Processing time in calendar days for paid bills			Carriers ranked by median ¹
		25th percentile	50th percentile (median)	75th percentile	
Alabama	Blue Shield	27. 0	36. 1	51. 1	51
Alaska	Aetna	5. 2	7. 4	13. 6	4
Arizona	do	6. 5	10. 2	14. 6	10
Arkansas	Blue Shield	21. 7	26. 6	39. 4	43
California	do	13. 6	17. 0	41. 5	30
	Occidental	7. 7	12. 5	19. 0	17
Colorado	Blue Shield	30. 0	37. 8	54. 2	52
Connecticut	Connecticut General.	15. 4	25. 1	41. 3	41
Delaware	Blue Shield	12. 9	15. 1	19. 5	25
District of Columbia	do	(2)	(2)	(2)	(2)
Florida	do	14. 8	21. 6	32. 7	33
Georgia	John Hancock	15. 8	25. 6	44. 0	42
Hawaii	Aetna	7. 4	13. 5	24. 5	20
Idaho	Equitable	7. 6	11. 2	14. 5	12
Illinois	Blue Shield	(3)	(3)	(3)	(3)
	Continental Casualty.	14. 1	22. 0	41. 3	34
Indiana	Blue Shield	18. 8	29. 0	48. 4	48
Iowa	do	13. 4	22. 9	49. 0	35
Kansas	B/S of Topeka	11. 9	23. 8	56. 0	39
	B/S of K.C., Mo.	(3)	(3)	(3)	(3)
Kentucky	Metropolitan	9. 0	13. 2	19. 4	19
Louisiana	Pan American	37. 8	46. 8	62. 6	54
Maine	Union Mutual	15. 8	20. 5	30. 1	31
Maryland	B/S of Maryland	10. 9	14. 6	20. 8	24
	Dist. of Col. B/S.	(2)	(2)	(2)	(2)
Massachusetts	Blue Shield	(2)	(2)	(2)	(2)
Michigan	do	22. 5	30. 2	49. 3	50
Minnesota	do	(3)	(3)	(3)	(3)
	Travelers	3. 1	6. 0	11. 6	1
Mississippi	do	2. 9	6. 0	15. 8	2
Missouri	Blue Shield	(3)	(3)	(3)	(3)
	Gen. American	17. 4	26. 9	41. 9	44
Montana	Blue Shield	11. 0	14. 2	18. 2	22
Nebraska	Mutual of Omaha	11. 6	15. 8	22. 0	26
Nevada	Aetna	5. 7	12. 2	26. 2	16
New Hampshire	Blue Shield	34. 3	47. 8	77. 3	55
New Jersey	Prudential	7. 1	11. 4	20. 9	13
New Mexico	Equitable	5. 4	8. 0	11. 3	7
New York	B/S of Buffalo	10. 9	17. 0	27. 8	29
	B/S of N.Y.C.	(2)	(2)	(2)	(2)
	B/S of Rochester	21. 3	28. 6	41. 7	46
	Metropolitan	9. 8	14. 1	19. 1	21
	Group Health	23. 3	42. 6	56. 4	53
North Carolina	Pilot Life	(2)	(2)	(2)	(2)
North Dakota	Blue Shield	7. 3	10. 5	16. 0	11
Ohio	Nationwide	44. 8	63. 4	79. 4	57
	B/S of Cleveland	15. 5	23. 6	34. 6	38
Oklahoma	Aetna	7. 0	11. 8	17. 8	14
	Dept. of Welfare	6. 5	8. 8	12. 5	8
Oregon	Aetna	5. 2	7. 4	13. 6	4
Pennsylvania	Blue Shield	7. 7	23. 1	33. 5	36
Rhode Island	do	14. 6	29. 6	55. 5	49
South Carolina	do	(3)	(3)	(3)	(3)
South Dakota	do	6. 4	8. 9	14. 9	9

See footnotes at end of table, p. 286.

Average Processing Time from Carrier's Receipt of Bill to Certification for Payment, April-June 1968, by State and Carrier Service Area—Continued

State	Carrier	Processing time in calendar days for paid bills			Carriers ranked by median ¹
		25th percentile	50th percentile (median)	75th percentile	
Tennessee-----	Equitable-----	9. 7	14. 4	23. 1	23
Texas-----	Blue Shield-----	(³)	(³)	(³)	(³)
Utah-----	do-----	14. 7	26. 9	49. 4	45
Vermont-----	do-----	34. 3	47. 8	77. 3	55
Virginia-----	Travelers-----	3. 7	7. 3	22. 0	3
	Dist. of Col. B/S--	(²)	(²)	(²)	(²)
Washington ⁴ -----	Blue Shield-----	18. 7	28. 8	34. 3	47
West Virginia-----	Nationwide-----	13. 1	21. 3	36. 7	32
Wisconsin-----	B/S of Madison-----	15. 2	16. 9	24. 8	28
	B/S of Milwaukee--	14. 6	23. 5	51. 5	37
Wyoming-----	Equitable-----	4. 3	7. 7	10. 7	6
Puerto Rico-----	Blue Shield-----	19. 7	24. 0	32. 8	40
Virgin Islands-----	Mutual of Omaha-----	11. 6	15. 8	22. 0	26
Railroad-----	Travelers-----	6. 8	12. 7	25. 0	18
	SSA-----	10. 3	12. 2	15. 4	15

¹ Rankings based on the 57 carrier service areas for which medians are available.

² Data not available for this quarter.

³ Data submitted found to be incorrect; corrected data not available.

⁴ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

5. (b) *Please rank each of the carriers on the basis of * * * proportion of claims which SSA must return for correction or change (or which SSA changes on its own) for the most recent quarter.*

Enclosed is a table listing, for each carrier service area, the proportion of payment records submitted by the carriers which SSA has determined to be incorrect because they include "accounting errors." The data apply to payment records processed by SSA in the period June 28, 1968 to August 29, 1968.

Certain computer edits and validity checks are performed on payment records submitted to SSA by the carriers. Those errors falling into the following classes are referred to as accounting errors, and payment records including any of them are returned to the carriers for correction:

- (1) Incorrect claim number and/or name
- (2) Beneficiary never enrolled in Part B
- (3) Incorrect reimbursement amount
- (4) Incorrect month of service
- (5) Beneficiary not enrolled in Part B in month(s) of service
- (6) Last expense month after month beneficiary died
- (7) Deductible not satisfied
- (8) Deductible over \$50
- (9) Incorrect jurisdiction of Railroad beneficiary claim
- (10) Blood charges with no prior query

Payment records which are found to include other errors which do not reflect possible overpayments or underpayments are not returned to the carriers and are excluded from the table.

*Proportion of Payment Records Returned to Carriers by SSA Because
of Accounting Errors, June 28, 1968, to Aug. 29, 1968*

State	Carrier	Percent of payment records with ac- counting errors	Rank ¹
Alabama	Blue Shield	10.0	65
Alaska	Aetna	2.7	50
Arizona	do	3.8	56
Arkansas	Blue Shield	1.2	34
California	do	5.8	60
	Occidental	.6	13
Colorado	Blue Shield	1.7	37
Connecticut	Connecticut General	3.1	52
Delaware	Blue Shield	3.2	53
District of Columbia	do	.7	17
Florida	do	1.0	30
Georgia	John Hancock	2.0	41
Hawaii	Aetna	1.1	32
Idaho	Equitable	.6	13
Illinois	Blue Shield	.9	28
	Continental Casualty	1.9	38
Indiana	Blue Shield	.8	26
Iowa	do	.5	6
Kansas	Blue Shield of Topeka	2.6	49
	Blue Shield of Kansas City, Mo.	(2)	(2)
Kentucky	Metropolitan	3.9	57
Louisiana	Pan American	2.2	44
Maine	Union Mutual	.4	1
Maryland	Blue Shield of Maryland	1.9	38
	District of Columbia Blue Shield	.7	17
Massachusetts	Blue Shield	3.7	55
Michigan	do	12.4	66
Minnesota	do	.9	28
	Travelers	.4	1
Mississippi	do	.6	13
Missouri	Blue Shield	6.0	61
	General American	2.1	43
Montana	Blue Shield	1.3	35
Nebraska	Mutual of Omaha	.5	6
Nevada	Aetna	4.0	58
New Hampshire	Blue Shield	9.7	64
New Jersey	Prudential	.4	1
New Mexico	Equitable	.7	17
New York	Blue Shield of Buffalo	.5	6
	Blue Shield of New York City	.5	6
	Blue Shield of Rochester	.7	17
	Metropolitan	2.2	44
	Group Health	.6	13
North Carolina	Pilot Life	1.0	30
North Dakota	Blue Shield	.7	17
Ohio	Nationwide	7.8	63
	Blue Shield of Cleveland	2.0	41
Oklahoma	Aetna	2.2	44
	Department of Welfare	2.3	47
Oregon	Aetna	2.7	50
Pennsylvania	Blue Shield	7.3	62
Rhode Island	do	1.1	32
South Carolina	do	.7	17
South Dakota	do	1.9	38

See footnotes at end of table, p. 288.

Proportion of Payment Records Returned to Carriers by SSA Because of Accounting Errors, June 28, 1968, to Aug. 29, 1968—Continued

State	Carrier	Percent of payment records with accounting errors	Rank ¹
Tennessee	Equitable	. 7	17
Texas	Blue Shield	. 7	17
Utah	do	1. 4	36
Vermont	do	(³)	(³)
Virginia	Travelers	. 8	26
	District of Columbia Blue Shield	. 7	17
Washington ⁵	Blue Shield	2. 4	48
West Virginia	Nationwide	4. 1	59
Wisconsin	Blue Shield of Madison	3. 4	54
	Blue Shield of Milwaukee	. 4	1
Wyoming	Equitable	. 5	6
Puerto Rico	Blue Shield	. 3	35
Virgin Islands	Mutual of Omaha	. 5	6
Railroad	Travelers	. 4	1
	SSA	. 5	6

¹ Rankings based on 66 carrier service areas.

² Data for Blue Shield of Missouri includes data for area services by this carrier in Kansas.

³ Data for New Hampshire and Vermont are combined.

⁴ Due to computer difficulties, only preliminary data available for August 2-28, 1968. These data show an accounting error rate of .5 percent for this carrier, based on over 178,000 payment records processed in the period.

⁵ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

5. (c) *Please rank each of the carriers on the basis of * * * proportion of claims pending over 30 days old for most recent quarter.*

The enclosed table presents a listing, for each carrier service area, of bills pending over 30 days, the ratio of clearances to receipts, and the number of weeks of work on hand. While the latter two items were not requested, it seems appropriate to include these additional performance indicators to assist in an evaluation of the extent to which carriers are managing their workloads.

Data have again been furnished in terms of bills rather than claims, as requested, since each claim may include several bills—each of which is processed separately and perhaps differently due to the variety in type of services for which reimbursement is claimed, degree of completeness of the bill and other factors affecting processing time. Thus, one bill may be processed in less than 30 days, while another—part of the same claim—may take over 30 days to process. It should be noted that a short-term increase in bill receipts tends to lower the proportion of bills pending over 30 days because it increases the relative number of “new” bills on hand. (Put another way, it reduces the average age of the pending workload.)

The ratio of clearances to receipts is an expression of the carrier's ability to keep bills from backlogging in the period being studied. Since it is expressed as a percentage, a figure of over 100.0 represents a reduction in pending loads. Conversely, a lower figure constitutes an increase in bills on hand at the end of the period. Clearly, there will

be times when the carrier cannot be expected to reduce its pending load. This occurs particularly at seasonal peaks such as early in the year (when bills are usually submitted in bunches until the deductible requirement is first met), or after epidemics.

Weeks of work on hand at the end of the period is a measure of the carrier's total backlog of cases relative to other carriers. It is computed as the product of the number of bills pending at the end of the period and the number of work weeks in the period, divided by the number of bills cleared in the period.

The data on bills pending over 30 days and on the number of weeks on hand are based on carriers' performance in June 1968. The data on the ratio of clearances to receipts are based on carrier operations for April through June 1968.

Proportion of bills in carrier offices pending over 30 days, ratio of carrier bill clearances to receipts, and number of weeks of work on hand in carrier offices

State	Carrier	Bills pending over 30 days ¹		Clearances ²		Weeks of work on hand	
		Percent of total pending	Carrier rank ³	Ratio to receipts (percent)	Carrier rank ³	Number of weeks	Carrier rank ³
Alabama	Blue Shield	30.2	64	115.9	6	2.9	42
Alaska	Aetna	10.3	30	99.5	54	.5	2
Arizona	do	2.5	8	104.7	33	1.0	8
Arkansas	Blue Shield	17.0	43	119.1	4	1.6	17
California	do	47.5	68	113.4	11	2.5	36
	do	10.9	31	94.5	64	2.8	41
Colorado	Occidental	21.3	50	104.5	34	4.8	65
Connecticut	Blue Shield	7.7	23	93.4	67	2.2	31
Delaware	Connecticut General	2.2	6	96.1	61	2.9	42
District of Columbia	Blue Shield	3.6	11	108.5	20	2.4	33
Florida	do	8.3	24	107.0	24	1.5	13
Georgia	John Hancock	19.9	46	113.8	9	2.1	29
Hawaii	Aetna	13.3	38	94.8	63	1.7	19
Idaho	Equitable	3.0	10	98.5	57	1.7	19
Illinois	Blue Shield	67.3	69	121.3	3	5.0	66
	Continental Casualty	8.6	26	106.6	27	1.6	17
Indiana	do	6.1	21	117.5	5	2.2	31
Iowa	Blue Shield	9.1	28	104.5	34	2.5	36
Kansas	Blue Shield of Topeka	28.6	63	93.7	65	4.6	64
	Blue Shield of Kansas City, Mo.	24.7	56	109.2	17	.4	1
Kentucky	Metropolitan	13.6	40	101.5	46	1.2	10
Louisiana	Pan American	12.0	34	115.3	7	1.7	19
Maine	Union Mutual	14.2	41	106.2	28	3.3	52
Maryland	Blue Shield of Maryland	24.9	57	98.9	56	3.9	59
	District of Columbia, Blue Shield	3.9	13	105.7	31	2.5	36
Massachusetts	Blue Shield	21.4	51	109.2	17	2.5	36
Michigan	do	26.3	58	110.9	14	3.3	52
Minnesota	do	26.9	59	106.2	28	3.4	54
	Travelers	1.9	4	102.0	44	.8	4
Mississippi	do	7.3	22	102.9	41	.6	3

Missouri	Blue Shield	20.3	47	112.3	12	1.7
	Gen. American	9.6	29	123.3	2	2.9
Montana	Blue Shield	2.8	9	102.8	42	2.1
Nebraska	Mutual of Omaha	14.6	42	111.2	13	2.0
Nevada	Aetna	12.5	35	110.5	15	.9
New Hampshire	Blue Shield	38.3	66	99.6	53	5.0
New Jersey	Prudential	8.8	27	103.3	39	2.0
New Mexico	Equitable	.6	2	98.0	59	1.8
New York	Blue Shield of Buffalo	28.4	62	103.1	40	3.6
	Blue Shield of New York City	11.2	32	100.5	51	2.5
	Blue Shield of Rochester	22.5	54	100.9	49	4.1
	Metropolitan	5.9	20	99.8	52	1.5
	Group Health	19.3	45	113.8	9	3.5
	Pilot Life	12.6	36	106.7	26	3.1
North Carolina	Blue Shield	8.4	25	105.8	30	1.3
North Dakota	Nationwide	47.3	67	93.7	65	3.9
Ohio	Blue Shield of Cleveland	22.3	53	108.6	19	4.4
Oklahoma	Aetna	4.0	14	99.0	55	2.0
	Department of Welfare	.3	1	101.2	48	1.7
Oregon	Aetna	2.4	7	107.7	21	.8
Pennsylvania	Blue Shield	28.3	61	107.0	24	2.9
Rhode Island	do	5.8	19	101.8	45	4.5
South Carolina	do	4.2	15	107.3	22	2.9
South Dakota	do	2.0	5	97.3	60	2.4
Tennessee	Equitable	11.7	33	110.0	16	3.1
Texas	Blue Shield	22.2	52	103.8	37	1.3
Utah	do	20.8	48	114.1	8	1.7
Vermont	do	35.6	65	89.9	68	12.2
Virginia	Travelers	4.6	16	102.6	43	.8
	District of Columbia Blue Shield	4.6	16	96.0	62	2.4
Washington	Blue Shield	21.0	49	107.1	23	2.9
West Virginia	Nationwide	13.3	38	105.6	32	1.5
Wisconsin	Blue Shield of Madison	22.7	55	101.5	46	3.6
	Blue Shield of Milwaukee	12.8	37	98.1	58	3.2
	Equitable	1.5	3	100.8	50	1.0
Wyoming	Blue Shield	3.6	11	103.7	38	3.6
Puerto Rico	Mutual of Omaha	28.2	60	64.4	69	7.1
Virgin Islands	Travelers	5.5	18	104.1	36	1.5
Railroad	SSA	17.6	44	144.1	1	3.0

³ Based on 69 carrier service areas.

¹ Based on carriers' operations in June 1968.

² Based on carriers' operations in April-June 1968.

5. (d) *Please rank each of the carriers on the basis of * * * administrative cost per claim handled (dollar amount, not proportion of benefit) for most recent quarter.*

The enclosed table presents the average (mean) cost per payment record processed by each carrier in the fiscal year ending June 30, 1968. As stated in previous questions, a payment record is a summary of one paid bill for services covered by the program. Data are presented for the fiscal year rather than for a calendar quarter so as to minimize the effects of seasonal and short-term variations in administrative costs in the comparison among the carriers.

The data exclude from the unit cost computation the number of bills processed by the carriers for which no payment was made (because of failure to meet the deductible requirement, nonenrolled status, exhaustion of benefits, etc.). However, there is no evidence to indicate that the proportion of no-payment bills processed varies significantly from carrier to carrier. Therefore, the unit costs shown in the table overstate somewhat, the average cost of handling a claim but by about the same proportion for each carrier.

Variations in administrative costs among carriers were larger during the initial year of operations (when there were comparatively large differences in one-time costs incurred for recruitment and training of personnel, systems development, and EDP programming) than during the second year. Some one-time costs, however, were incurred in fiscal year 1968 in connection with improvements in operations. For example, a company may have automated its Medicare operations because the workload increased to the point where automation has become feasible, or a carrier may have converted from one computer system to a more sophisticated one to secure longer term cost reductions although costs may have been increased in the year of change.

Other variations in unit costs relate to normal differences in costs of doing business in various sections of the country. There are differences in the labor market in various cities in which carrier Medicare operations are based and differences in local wage scales. For example, there is a difference of approximately 70 percent between the lowest and highest average salaries of one carrier for the same job in different service areas.

In addition, a significant factor accounting for differences in unit costs is the size of Medicare operations. The largest carrier, for example, has a workload about 46 times greater than the smallest. (This calculation was based on the number of payment records processed in the first 9 months of fiscal year 1968 as reported by the carriers.) Experience has shown that a higher volume of work generally permits a lower unit cost. Specifically, larger companies can feasibly use more sophisticated EDP and other accounting equipment, which usually produce a lower unit cost. There is, as could be expected, a statistically significant negative correlation between administrative cost per payment record processed and productivity per man-year.

(That is, generally speaking, the higher the average of cases processed per carrier employee in a given period of time, the lower the administrative cost per bill processed.)

Carrier costs vary somewhat depending upon the ratio of assigned to unassigned medical bills. Staffs of doctors' offices are more experienced than beneficiaries in filling out Medicare forms. Thus, assigned bills generally have fewer errors and are less expensive to process than unassigned bills. Of course, where carriers do adequate jobs of explaining Medicare to medical secretaries and other in the medical community, the percentage of claims requiring additional information in order to complete bill processing is significantly reduced further, but, of course, these carriers have the cost of professional contacts.

Another factor is the character of the service area. For example, some carriers have multi-State service areas which are not contiguous. Other carriers have a single, discreet service area which—other things being equal—tends to produce lower unit costs.

To some degree, variations in cost per claim may also reflect a more extensive claims review on the part of some carriers, including the application of more effective utilization safeguards. Some companies were better equipped initially, in terms of their systems and machine capability, to perform a higher quality job at the beginning of the program. For example, development of physician profiles and their application in determining reasonable charges significantly affect cost. At the outset, some carriers had the capability to implement this concept in reimbursement more rapidly than other companies, while other carriers incurred substantial one-time costs in establishing the more sophisticated systems required to develop information with respect to physicians' charges.

Each carrier files a quarterly cost report with the Social Security Administration. Comparisons are made among companies following submission of their periodic cost reports, and SSA attempts to determine the reason for significant variations in unit costs. Cost differences are discussed with the companies to determine what remedial actions may be undertaken to reduce unduly high costs.

*Average administrative cost per payment record processed, by carrier,
fiscal year 1968*

State	Carrier	Unit cost (in dollars)	Rank ¹
Alabama	Blue Shield	3. 36	22
Alaska	Aetna	(2)	-----
Arizona	do	(2)	-----
Arkansas	Blue Shield	3. 12	12
California	do ³	2. 63	4
	Occidental	3. 68	29
Colorado	Blue Shield ³	3. 67	27
Connecticut	Connecticut General	2. 52	2
Delaware	Blue Shield	6. 14	51
District of Columbia	do	(2)	-----
Florida	do	2. 74	6
Georgia	John Hancock	5. 81	50
Hawaii	Aetna	(2)	-----
Idaho	Equitable	(2)	-----
Illinois	Blue Shield	4. 34	45
	Continental Casualty	3. 26	18
Indiana	Blue Shield	3. 47	23
Iowa	do	3. 32	20
Kansas	Blue Shield of Topeka ³	3. 75	33
	Blue Shield of Kansas City, Missouri.	(2)	-----
Kentucky	Metropolitan	(2)	-----
Louisiana	Pan American	4. 69	47
Maine	Union Mutual	3. 82	36
Maryland	Blue Shield of Maryland	4. 07	42
	District of Columbia Blue Shield.	(2)	-----
Massachusetts	Blue Shield	3. 07	10
Michigan	do	3. 01	8
Minnesota	do ³	4. 32	43
	Travelers	(2)	-----
Mississippi	do	(2)	-----
Missouri	Blue Shield	(2)	-----
	General American	3. 54	25
Montana	Blue Shield	3. 69	30
Nebraska	Mutual of Omaha	(2)	-----
Nevada	Aetna	(2)	-----
New Hampshire	Blue Shield	(2)	-----
New Jersey	Prudential	2. 66	5
New Mexico	Equitable	(2)	-----
New York	Blue Shield of Buffalo	5. 06	48
	Blue Shield of New York City.	3. 29	19
	Blue Shield of Rochester	3. 94	40
	Metropolitan	(2)	-----
	Group Health	4. 60	46
North Carolina	Pilot Life	3. 33	21
North Dakota	Blue Shield	3. 86	38
Ohio	Nationwide	(2)	-----
	Blue Shield of Cleveland	3. 76	35
Oklahoma	Aetna	(2)	-----
	Department of Welfare	2. 54	3
Oregon	Aetna	(2)	-----
Pennsylvania	Blue Shield	2. 33	1
Rhode Island	do	3. 14	13
South Carolina	do	3. 10	11
South Dakota	do	3. 68	28
Tennessee	Equitable	(2)	-----
Texas	Blue Shield	3. 76	34

See footnotes at end of table, p. 295.

*Average administrative cost per payment record processed, by carrier,
fiscal year 1968—Continued*

State	Carrier	Unit cost (in dollars)	Rank ¹
Utah.....	do.....	3. 57	26
Vermont.....	do.....	(2) -----	
Virginia.....	Travelers.....	(2) -----	
	District of Columbia Blue Shield.....	(2) -----	
Washington ⁴	Blue Shield.....	3. 75	32
West Virginia.....	Nationwide.....	(2) -----	
Wisconsin.....	Blue Shield of Madison.....	3. 84	37
	Blue Shield of Milwaukee.....	3. 96	41
Wyoming.....	Equitable.....	(2) -----	
Puerto Rico.....	Blue Shield.....	2. 75	7
Virgin Islands.....	Mutual of Omaha.....	(2) -----	
Railroad.....	Travelers.....	3. 25	17
	SSA.....	(5) -----	(5)
	Aetna ⁶	3. 06	9
	District of Columbia Blue Shield. ⁷	4. 33	44
	Equitable ⁸	3. 48	24
	Blue Shield of Kansas City, Mo. ⁹	5. 32	49
	Metropolitan ¹⁰	3. 23	16
	Travelers (except RRB) ¹¹	3. 14	14
	Mutual of Omaha ¹²	3. 21	15
	New Hampshire-Vermont Blue Shield.....	3. 74	31
	Nationwide ¹³	3. 68	39

¹ Rankings based on 51 carriers, counting Travelers' service of railroad retirement annuitants as a separate entity.

² Data for separate components of multi-State carriers not available; unit costs for total operations of such carriers are shown at end of table.

³ Preliminary data.

⁴ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁵ Not applicable.

⁶ Aetna has separate service areas in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon.

⁷ District of Columbia Blue Shield has separate service areas in the District of Columbia, Maryland, and Virginia.

⁸ Equitable has separate service areas in Idaho, New Mexico, Tennessee, and Wyoming.

⁹ Blue Shield of Kansas City, Mo., has separate service areas in Kansas and Missouri.

¹⁰ Metropolitan has separate service areas in Kentucky and New York.

¹¹ Travelers has separate service areas in Minnesota, Mississippi, and Virginia.

¹² Mutual of Omaha has separate service areas in Nebraska and the Virgin Islands.

¹³ Nationwide has separate service areas in Ohio and West Virginia.

5. (e) Please rank each of the carriers on the basis of * * * proportion of claims returned to the claimant (or to the provider of the service) with questions or requests for additional information for most recent quarter.

The enclosed table lists, for each carrier service area, the proportion of bills requiring additional development (i.e., securing further information or documentation upon which to base an adjudication of the claim for reimbursement). Data on bills, rather than claims, are furnished.

The proportion of bills requiring additional development is an indicator of the frequency with which carriers must undertake extra handling of bills to complete their processing. The carriers have been ranked as requested. Submission of incomplete or incorrect bills by

patients or physicians and other suppliers of covered services cannot be cited as necessarily a fault of the carrier. However, with respect to those claims forms completed in physicians' offices, carriers can, to some extent, reduce the number of such bills by mounting an effective professional relations program. On the other hand, the data for some carriers may show a proportion of bills requiring additional development which is relatively high because they do a more thorough job of claims review (as a result of which they identify and report a higher than average proportion of bills requiring additional development).

It should be noted that, beginning November 1967, carriers were instructed to secure any required additional information or documentation through their own efforts in lieu of returning incomplete bills to claimants. However, the carriers are still required to maintain an inventory of such cases.

Proportion of carrier receipts for which additional information or documentation must be obtained before adjudication, April-June 1968

State	Carrier	Bills requiring additional development	
		Percent	Rank 1
Alabama	Blue Shield	2.4	9
Alaska	Aetna	8.8	36
Arizona	do	9.8	46
Arkansas	Blue Shield	2.0	6
California	do	1.0	2
	Occidental	11.0	54
Colorado	Blue Shield	6.1	20
Connecticut	Connecticut General	4.9	17
Delaware	Blue Shield	9.3	39
District of Columbia	do	11.4	55
Florida	do	20.6	68
Georgia	John Hancock	2.3	7
Hawaii	Aetna	9.5	42
Idaho	Equitable	9.7	44
Illinois	Blue Shield	7.1	28
	Continental Casualty	4.5	16
Indiana	Blue Shield	3.0	12
Iowa	do	8.7	35
Kansas	Blue Shield of Topeka	6.4	22
	Blue Shield of Kansas City, Missouri	10.2	51
Kentucky	Metropolitan	4.1	14
Louisiana	Pan American	(2)	(2)
Maine	Union Mutual	6.6	24
Maryland	Blue Shield of Maryland	10.0	50
	District of Columbia Blue Shield	8.8	36
Massachusetts	Blue Shield	1.7	4
Michigan	do	11.6	56
Minnesota	do	9.4	41
	Travelers	11.6	56
Mississippi	do	7.2	29
Missouri	Blue Shield	10.2	51
	Gen. American	9.9	48
Montana	Blue Shield	12.7	60
Nebraska	Mutual of Omaha	10.2	51
Nevada	Aetna	6.2	21

See footnotes at end of table, p. 297.

Proportion of carrier receipts for which additional information or documentation must be obtained before adjudication, April-June 1968.—Continued

State	Carrier	Bills requiring additional development	
		Percent	Rank ¹
New Hampshire	Blue Shield	7.2	29
New Jersey	Prudential	16.0	66
New Mexico	Equitable	19.3	67
New York	Blue Shield of Buffalo	3.7	13
	Blue Shield of New York City	9.0	38
	Blue Shield of Rochester	12.4	59
	Metropolitan	6.0	19
	Group Health	6.7	27
North Carolina	Pilot Life	9.5	42
North Dakota	Blue Shield	9.7	44
Ohio	Nationwide	4.2	15
	Blue Shield of Cleveland	13.3	62
Oklahoma	Aetna	15.2	65
	Department of Welfare	1.1	3
Oregon	Aetna	12.1	58
Pennsylvania	Blue Shield	13.3	62
Rhode Island	do	2.3	7
South Carolina	do	6.6	24
South Dakota	do	8.0	31
Tennessee	Equitable	8.6	34
Texas	Blue Shield	6.5	23
Utah	do	9.3	39
Vermont	do	8.1	32
Virginia	Travelers	6.6	24
	District of Columbia Blue Shield	8.3	33
Washington ³	Blue Shield	12.8	61
West Virginia	Nationwide	2.5	11
Wisconsin	Blue Shield of Madison	9.9	48
	Blue Shield of Milwaukee	13.3	62
Wyoming	Equitable	9.8	46
Puerto Rico	Blue Shield	2.4	9
Virgin Islands	Mutual of Omaha	.9	1
Railroad	Travelers	5.7	18
	SSA	1.7	4

¹ Based on the 68 carrier service areas for which data are available for the quarter.

² Data not reported for the April-June 1968 quarter. However, the proportion of bills requiring additional development in July 1968 was 3.3 percent.

³ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

5. (f) *Please rank each of the carriers on the basis of * * * proportion of claims which beneficiaries appealed and the disposition of such cases for calendar 1967.*

Enclosed is a table which presents, for each carrier service area, the proportion of total claims processed in which informal reviews were requested, the proportion of informal reviews which were sustained, the proportion of sustained informal reviews in which fair hearings were requested, and the proportion of fair hearings which were sustained. Complete data for the first half of calendar year 1967 were not collected so that information for fiscal year 1968 is presented instead of data for 1967.

The only ranking shown is for the proportion of total claims processed in which informal reviews were requested. The data are ranked showing the lowest proportion of informal reviews as the first rank. The proportion reviewed reflects not only dissatisfaction with carrier determinations but also ease of access to review provided by the carrier and percentage of claims which are derived or reduced which, to some degree, reflects quality of claims review.

If the carrier is not doing an effective job of claims review, the claimants might have relatively few complaints about reasonable charge determinations or the amounts reimbursed. Thus, relatively few informal reviews would be requested, and the carrier would experience a low proportion of informal reviews.

Informal reviews and fair hearings conducted by carriers, fiscal year 1968

State	Carrier	Informal reviews		Fair hearings	
		Total		Total, as percent of sustained informal reviews	
		As a percent of claims processed	Rank ¹	Percent of total sustained	Percent of total fair hearings sustained
Alabama	Blue Shield	0.05	33	71.6	(2)
Alaska	Aetna	.05	33	100.0	(2)
Arizona	do	.03	25	94.8	16.4
Arkansas	Blue Shield	.02	20	84.0	83.3
California	do	.13	46	49.7	.2
	Occidental	.05	33	63.1	8.7
Colorado	Blue Shield	.02	20	33.8	100.0
Connecticut	Connecticut General	.01	11	95.3	100.0
Delaware	Blue Shield	.03	25	4.4	18.0
District of Columbia	do	1.08	64	65.2	(3)
Florida	do	.36	56	32.9	1.3
Georgia	John Hancock	.01	11	100.0	4.5
Hawaii	Aetna	.01	11	80.0	(2)
Idaho	Equitable	.001	7	100.0	0
Illinois	Blue Shield	.16	48	27.6	(2)
	Continental Casualty	.10	43	40.7	3.6
Indiana	Blue Shield	.13	46	40.2	1.0
Iowa	do	.31	55	64.5	.3
Kansas	Blue Shield of Topeka	1.23	66	83.9	.4
	Blue Shield of Kansas City, Mo.	.40	57	82.9	.1
Kentucky	Metropolitan	.01	11	67.6	0
Louisiana	Pan American	.26	52	81.5	15.0
Maine	Union Mutual	.08	40	68.2	0
Maryland	Blue Shield of Maryland	.03	25	96.6	(2)
	District of Columbia Blue Shield	1.06	62	41.8	26.3
Massachusetts	Blue Shield	0	1	(2)	1.9
Michigan	do	.03	25	61.1	(2)
				19.3	78.4

See footnotes at end of table, p. 301.

Informal reviews and fair hearings conducted by carriers, fiscal year 1968—Continued

State	Carrier	Informal reviews		Fair hearings	
		Total		Percent of total	
		As a percent of processed	Rank	of sustained in- formal reviews	fair hearings sustained
Minnesota	Blue Shield	.07	37	78.0	(2)
	Travelers	.28	54	90.6	100.0
Mississippi	do	.56	59	96.0	100.0
Missouri	Blue Shield	.21	50	83.3	100.0
	General American	.01	11	65.5	(2)
Montana	Blue Shield	.04	30	82.5	(2)
Nebraska	Mutual of Omaha	0	1	(2)	(2)
Nevada	Aetna	0	1	(2)	(2)
New Hampshire	Blue Shield	.11	44	75.0	100.0
New Jersey	Prudential	.08	40	78.3	100.0
New Mexico	Equitable	.01	11	100.0	(2)
New York	Blue Shield of Buffalo	.01	11	28.6	(2)
	Blue Shield of New York City	.05	33	52.5	(2)
	Blue Shield of Rochester	.21	50	56.1	(2)
	Metropolitan	.004	10	80.0	66.7
	Group Health	1.73	67	44.8	57.5
	Pilot Life	.02	20	44.1	(2)
North Carolina	Blue Shield	0	1	(2)	(2)
North Dakota	Nationwide	.01	11	100.0	(2)
Ohio	Blue Shield of Cleveland	.07	37	60.2	100.0
	Aetna	.16	48	89.8	60.0
Oklahoma	Department of Welfare	0	1	(2)	(2)
Oregon	Aetna	.02	20	76.7	100.0
Pennsylvania	Blue Shield	.27	53	64.3	99.2
Rhode Island	do	.07	37	74.7	100.0
South Carolina	do	1.07	63	69.4	(2)
South Dakota	do	.69	60	94.6	100.0
Tennessee	Equitable	.01	11	97.4	50.0
Texas	Blue Shield	.001	7	100.0	(2)
Utah	do	.03	25	48.3	100.0

5. (g) *Please rank each of the carriers on the basis of * * * proportion of cases where submitted physician charges were higher than carrier-determined reasonable charges for the most recent quarter.*

For each geographical area within which the concept of prevailing charges is applied, give the number of the eight most frequently reimbursed services which have been changed in the period from October 1, 1966 to April 1, 1968. By how much in each area and when?

The determination of "reasonable" charges under Medicare is the responsibility of the Nation's carriers to whom bills for services under the supplementary medical insurance program are sent for payment. Carriers operate under agreement with the Secretary of Health, Education, and Welfare, and use guidelines issued by the Social Security Administration in determining reasonable charges under the program.

The enclosed tables present preliminary data from bills paid by carriers for a 5-percent sample of beneficiaries who received services under the SMI program and who met the \$50 annual deductible. The bills are sent to SSA after payment. They are coded, punched, and tabulated to compile statistics for program evaluation purposes.

The tables show the number of services billed, the proportion of services where the reasonable charge (the charge allowed by the carrier) was less than the total charge (the charge billed by the physician), the average total charge per service, and the percent reduction from total to allowed charges. Figures are presented for all services and for individual broad categories of type of service, i.e., medical care, surgery, consultation, anesthesia, etc. The tables are based on bills received and processed into SSA records by the beginning of September 1968. Data are presented by date of service and not the date of payment of the bill.

Table 1 presents comparative national data for bills for services rendered in four six-month periods—the second half of 1966, the first half of 1967, the second half of 1967, and the first half of 1968. Table 2 presents data for individual carriers for the last two of these six-month periods in order to focus primarily on carriers' "current" activity in establishing reasonable charges.

The figures in Table 1 show a consistently upward trend in both the percent of services where the charge allowed was less than that billed by the physician and the percent reduction from average total charge to average reasonable charge. However, because of delays associated with submittal of bills to carriers by physicians and beneficiaries, and because of normal lags in carrier and SSA processing, the tabulated figures represent a far smaller proportion of all services rendered in the first half of 1968 than to the bills for the last half of 1967.

In fact, the services tabulated for 1968 represent only 30–35 percent of the services tabulated for earlier periods. These data are being re-tabulated. It is expected that the figures for 1968 will change more substantially than those for earlier periods although the trend is not likely to change.

The underrepresentation of bills for services rendered in 1968 is especially important when examining and interpreting the figures for individual carriers in Table 2. Since the numbers are much smaller for individual carriers, they are subject to much larger changes as the completeness of reporting increases.

The figures in Table 2 show that both the percent of services for which the charge was reduced and the percent reduction in average total charge was higher for most carriers in the first six months of 1968 compared with the last six months of 1967. However, there are many carriers with different patterns, i.e., no change or decreases in the percent of changes between the two successive six-month periods being examined. In addition, the percent reduced, whether related to services or charges, varies significantly among individual carriers.

The figures in the enclosed tables cannot be used as definitive measures of carrier performance in determining "reasonable" charges. A wide variety of factors that are not self-evident contribute to the differences shown. Generally, for example, assigned bills are sent in for reimbursement earlier than unassigned bills and are probably less likely to be reduced. The latter may consist typically of small bills which the patient holds until they are cumulated to over \$50, or until the end of the year. The bills for which a doctor accepts assignment may be a bill for a single expensive procedure such as surgery, consultation or anesthesia. Thus, the "mix" of bills received for 1968 most likely includes a higher proportion of assigned bills than the figures tabulated for July-December 1967.

Differences in carrier operations and physician practices over time may also be reflected in the figures shown in the tables. Both carriers and physicians may have reached a better understanding of the "reasonable" charge concept or the level of charges accepted by physicians may reflect their previous experience under widely held private coverages of the carriers, so that the frequency of bills for which the charges were greater than that defined as "reasonable" would tend to diminish. At the same time, a change in the level of customary charges introduced by the physician, or a more rigorous application of the guidelines by the carrier would act to increase the number of services for which charges are reduced. The figures shown in the tables thus result from the total interaction of the patterns of physicians' charges and carrier performance and cannot be interpreted without further knowledge of both these factors.

It should be clearly noted that the data in the enclosed tables cannot be equated to physicians' charges or fees, nor can they be used to measure changes in fees during the period covered by the report. The data are grouped broadly by "type of service." Each "type of service" includes a wide variety of specific procedures from the very complex and expensive to the very simple and inexpensive. For example, "surgery" includes such diverse procedures as complex cardiac operations, cleansing and suture of a small laceration, or a proctoscopic examination. The average total charge for all services or for various types of service is determined by the level of charges for *specific* procedures and by the frequency with which they are represented in the data. Such a change in the "mix" of specific procedures in the data may explain the fact that the average total charge for surgery apparently declined for the first three of the time periods shown in Table 1 and then increased. To measure changes in physician fees over time, data for the same procedure are required. Such data are being compiled and will be made available shortly.

Table 1 - Medicare: Number and percent of services where allowed charge less than total charge and percent reduction from average total to average allowed charge by type and date of service, July 1966 - June 1968

[Preliminary data based on 5 percent sample bills processed through August 1968]

Type of Service	July - December 1966				January - June 1967			
	Number of Services	Percent Where Charge Reduced	Average Total Charge	Average Allowed Charge	Number of Services	Percent Where Charge Reduced	Average Total Charge	Average Allowed Charge
All Services ^{1/}	2,292,547	3.9%	\$11.59	\$11.31	2,813,292	4.2%	\$11.15	\$10.84
Medical Care	1,806,118	3.8	6.82	6.68	2,202,416	4.0	6.96	6.80
Surgery	67,451	6.9	136.10	131.76	73,988	7.6	131.08	126.29
Consultation	23,490	6.8	20.15	19.24	28,667	8.1	21.42	20.32
Diagnostic X-ray	77,852	3.2	14.74	14.49	95,640	3.1	14.53	14.29
Diagnostic Laboratory	246,973	3.2	5.42	5.32	328,165	3.5	5.44	5.32
Anesthesia	16,617	7.0	56.48	55.32	17,143	7.8	58.64	57.25
Assistance at Surgery	4,935	6.4	60.47	58.35	5,235	9.0	65.70	62.17
All Services ^{1/}	2,416,619	4.9%	\$10.54	\$10.23	856,149	6.4%	\$12.29	\$11.90
Medical Care	1,897,582	4.8	7.00	6.82	664,925	6.2	7.67	7.46
Surgery	56,912	8.8	120.47	115.94	21,865	11.4	143.22	137.98
Consultation	25,815	10.8	21.56	20.23	9,603	13.2	24.11	22.52
Diagnostic X-ray	77,430	4.2	14.32	13.99	33,385	5.6	14.45	14.05
Diagnostic Laboratory	286,236	4.6	5.50	5.35	95,879	6.5	5.93	5.70
Anesthesia	11,854	10.7	58.18	56.26	5,425	13.4	62.90	60.55
Assistance at Surgery	3,668	11.6	66.69	63.02	1,855	11.9	65.10	61.74
All Services ^{1/}	2,416,619	4.9%	\$10.54	\$10.23	856,149	6.4%	\$12.29	\$11.90
Medical Care	1,897,582	4.8	7.00	6.82	664,925	6.2	7.67	7.46
Surgery	56,912	8.8	120.47	115.94	21,865	11.4	143.22	137.98
Consultation	25,815	10.8	21.56	20.23	9,603	13.2	24.11	22.52
Diagnostic X-ray	77,430	4.2	14.32	13.99	33,385	5.6	14.45	14.05
Diagnostic Laboratory	286,236	4.6	5.50	5.35	95,879	6.5	5.93	5.70
Anesthesia	11,854	10.7	58.18	56.26	5,425	13.4	62.90	60.55
Assistance at Surgery	3,668	11.6	66.69	63.02	1,855	11.9	65.10	61.74

^{1/} Includes miscellaneous services such as rental of durable medical equipment and ambulance services not shown separately.

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Table 2 - Medicare: Total number of services, percent where allowed charge less than total charge, average total charge and percent reduction from total to allowed charge by geographic division, State, carrier, and date of service, July 1967 - June 1968

Geographic Division, State, Carrier and Date of Service	All Services 1/				L Care				Surgery				Consultation				Diagnostic X-ray				Diagnostic Lab				Anesthesia				Asst. of Surgery			
	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced	Number of services	Where charge reduced	Average total charge	Percent reduced
All Carriers	2,416,619	6.9%	\$10.54	3.0%	1,897,582	4.8%	\$ 7.00	2.6%	56,912	8.8%	\$120.47	3.8%	25,815	10.8%	\$21.56	6.2%	77,430	4.2%	\$14.32	2.3%	288,236	4.6%	\$5.50	2.7%	11,854	10.7%	\$58.18	3.7%	3,688	11.6%	\$66.69	5.5%
January-June 1968	856,149	6.4%	12.29	3.2	684,925	6.2	7.67	2.7	18,865	11.4	143.22	3.7	9,603	13.2	24.11	6.6	33,385	5.6	14.45	2.8	99,879	6.5	5.93	3.9	5,425	13.4	82.90	3.7	1,855	11.9	85.10	5.2
New England																																
Maine (Union Mutual)	16,144	1.4	8.18	1.0	14,052	1.2	5.88	0.5	345	3.5	87.04	1.7	128	2.3	16.43	1.2	496	0.4	9.13	0.5	893	0.1	4.77	0.0	68	11.8	43.68	4.1	37	5.4	35.34	1.9
July-December 1967	5,365	3.7	9.35	2.3	4,500	3.5	6.39	1.1	129	10.9	104.01	4.1	47	2.1	16.19	1.3	284	0.4	7.23	0.6	225	0.3	3.24	0.8	2/	2/	2/	2/	2/	2/	2/	2/
January-June 1968																																
New Hampshire (B/S)	17,168	0.4	8.86	1.3	14,743	0.1	6.02	0.8	334	4.5	111.31	2.4	129	1.6	19.19	1.5	603	0.2	10.16	0.1	865	1.5	5.68	0.4	73	16.4	44.64	3.2	74	1.4	42.97	0.4
July-December 1967	4,195	0.5	9.42	0.6	3,610	0.1	6.15	0.2	85	5.9	120.73	1.6	35	0.0	10.44	0.0	162	3.1	10.04	0.8	160	3.8	6.63	2.1	25	12.0	61.76	5.6	2/	2/	2/	2/
January-June 1968																																
Massachusetts (B/S)	46,855	3.0	12.38	2.1	38,565	3.0	8.26	1.6	1,420	5.8	108.63	3.2	694	5.3	23.02	4.4	1,354	1.0	12.94	2.1	3,028	1.6	6.54	1.4	396	6.6	53.71	2.0	113	7.1	51.05	5.7
July-December 1967	21,583	3.7	13.59	1.6	18,804	3.9	8.73	1.6	654	6.0	125.21	1.9	300	7.8	23.94	3.6	961	0.4	12.68	0.3	1,002	1.6	6.22	1.5	228	10.5	54.76	2.3	61	6.6	54.48	1.3
January-June 1968																																
Rhode Island (B/S)	8,787	3.1	13.22	2.5	7,373	2.9	9.20	1.2	173	16.0	160.57	6.3	107	6.5	30.14	3.6	216	1.4	14.35	0.5	653	1.2	6.05	0.8	31	6.6	54.48	1.3	47	6.4	67.87	2.0
July-December 1967	5,578	2.3	13.69	1.7	5,055	1.9	9.62	0.7	61	11.5	152.34	4.6	49	10.2	25.92	2.8	107	0.9	15.80	0.3	169	0.6	6.69	0.2	6	16	74.81	3.5	2/	2/	2/	2/
January-June 1968																																
Connecticut (Conn. Gen.)	25,328	4.3	13.76	2.3	20,897	3.9	8.96	1.6	771	10.9	132.75	3.7	323	14.2	21.94	7.6	768	2.6	18.37	1.3	1,748	2.2	7.06	1.0	101	3.0	57.70	0.8	28	28.6	65.57	6.8
July-December 1967	16,695	7.7	14.92	3.1	11,878	6.8	9.44	2.2	426	12.9	154.96	4.0	251	13.5	22.59	6.6	409	6.1	19.95	2.2	1,104	8.3	6.39	3.0	38	10.3	49.72	1.4	2/	2/	2/	2/
January-June 1968																																
Middle Atlantic																																
New York																																
(Group Health)	13,305	21.3	13.03	7.5	10,468	20.9	9.41	6.2	287	25.1	117.73	10.2	230	20.0	29.29	13.2	369	27.1	23.73	6.0	1,603	20.3	6.36	9.4	82	37.8	86.37	8.9	2/	2/	2/	2/
July-December 1967	3,603	50.5	15.61	9.4	2,630	31.1	11.82	9.7	108	41.7	112.89	8.0	53	45.5	28.25	17.2	148	30.8	24.83	8.0	571	29.4	6.90	12.5	2/	2/	2/	2/	2/	2/	2/	2/
January-June 1968																																
Metropolitan	51,214	2.8	10.21	1.8	44,905	2.8	6.68	2.1	1,198	5.8	113.96	1.5	467	0.2	23.02	0.1	764	1.8	17.54	0.8	2,394	2.3	6.68	1.5	294	4.4	59.30	0.8	133	11.3	51.72	3.5
July-December 1967	26,520	2.8	11.65	2.2	22,603	2.4	6.99	2.3	719	12.1	125.85	2.1	301	0.3	22.49	0.1	408	2.7	17.38	1.0	1,388	3.5	6.50	2.0	267	3.0	59.18	0.7	95	8.4	57.44	2.0
January-June 1968																																
(Buffalo - B/S)	15,204	0.8	12.33	0.7	12,684	0.5	7.49	0.3	697	2.6	119.94	1.4	178	1.7	26.33	0.7	636	1.4	12.54	0.2	892	1.8	7.17	0.6	128	9.4	58.81	1.1	43	2.3	55.98	0.4
July-December 1967	7,588	0.7	14.00	0.5	6,163	0.2	7.71	0.0	301	4.3	119.53	0.7	99	1.0	33.51	0.6	376	2.4	13.70	1.1	1,398	1.5	8.20	0.9	102	8.8	60.36	1.4	2/	2/	2/	2/
January-June 1968																																
(New York City - B/S)	157,071	28.7	14.26	13.5	114,022	30.3	9.90	12.2	4,006	40.0	142.08	17.0	3,434	40.1	28.28	20.9	4,326	26.5	22.32	9.7	28,866	19.2	6.34	11.7	1,011	34.6	80.44	10.0	124	16.1	84.28	20.0
July-December 1967	67,112	25.0	16.03	10.6	46,626	26.2	10.92	9.2	1,855	34.1	168.88	12.4	1,596	35.7	28.32	16.9	2,260	27.1	22.33	10.1	12,779	17.5	6.58	9.9	540	38.5	83.67	10.6	71	28.2	68.69	12.5
January-June 1968																																
(Rochester - B/S)	10,884	1.0	12.59	2.0	9,011	0.2	7.30	0.3	361	6.5	138.03	0.3	108	9.3	17.56	3.9	170	1.2	28.20	0.3	811	4.0	5.36	0.0	119	45.4	56.48	14.5	5/	2/	2/	2/
July-December 1967	5,012	1.3	19.70	0.9	2,434	0.5	8.13	0.0	190	2.1	153.43	0.4	2/	2/	2/	2/	41	2.4	35.78	1.3	139	1.4	4.65	1.3	59	35.6	44.37	9.4	2/	2/	2/	2/
January-June 1968																																
New Jersey (Prudential)	86,331	0.8	12.43	1.0	70,336	0.7	8.65	0.4	1,898	2.9	135.00	1.9	1,505	0.7	25.07	0.3	1,577	3.4	17.54	1.3	6,702	0.7	6.96	0.4	595	6.4	58.42	2.2	107	4.7	85.28	1.8
July-December 1967	44,063	2.0	14.60	1.3	36,457	2.0	9.42	0.6	1,100	4.3	164.46	1.5	810	1.0	26.89	2.6	1,907	2.3	17.88	1.4	3,428	1.2	7.22	0.6	366	9.8	65.18	3.1	85	4.7	62.44	2.0
January-June 1968																																
Pennsylvania (B/S)	169,905	4.4	9.85	2.6	144,201	4.2	6.91	1.9	4,200	7.8	99.80	4.3	2,204	16.8	19.86	8.0	2,375	8.3	18.59	3.4	13,618	2.7	6.11	2.0	563	2.6	45.28	0.8	56	16.1	53.64	10.6
July-December 1967	60,448	3.7	11.69	2.2	51,580	3.2	7.69	1.4	1,609	10.1	126.85	3.1	767	19.8	22.51	8.8	835	6.0	20.36	3.5	4,467	4.6	6.55	2.5	272	7.0	51.47	2.0	49	18.3	43.90	18.6
January-June 1968																																
East North Central																																
Ohio																																
(B/S)	14,846	5.6	12.20	4.5	11,307	6.3	7.19	3.3	665	15.5	133.20	8.1	217	5.1	20.30	3.2	819	1.3	9.51	1.0	1,423	1.1	6.80	0.7	116	6.0	49.29	2.7	2/	2/	2/	2/
July-December 1967	5,836	2.1	17.69	3.4	2,665	1.0	7.21	0.4	181	17.7	187.96	5.8	47	10.6	24.89	5.6	401	0.7	9.27	0.7	298	1.0	8.80	0.5	62	16.5	55.73	4.6	2/	2/	2/	2/
January-June 1968																																
(Baltimore)	75,147	0.3	9.46	0.4	63,572	0.3	6.36	0.6	1,327	0.9	134.92	0.3	492	0.6	15.21	0.9	2,085	0.3	11.17	0.3	5,685	2/	5.43	0.4	487	0.6	52.58	0.4	89	2.1	53.29	1.8
July-December 1967	12,587	0.3	11.86	0.5	10,418	2/	6.98	0.2	288	1.7	165.65	0.9	86	2.3	18.56	0.5	463	0.5	12.05	0.3	1,148	0.4	3.22	0.2	122	0.8	56.42	1.4	2/	2/	2/	2/
January-June 1968																																
Indiana (B/S)	31,561	3.0	9.64	1.8	26,292	3.1	5.90	1.4	781	6.1	115.69	2.7	220	4.5	12.92	2.7	973	1.5	10.08	1.4	2,133	1.0	5.43	0.6	238	7.1	69.84	2.3	54	9.3	71.07	4.3
July-December 1967	3,975	6.5	12.62	2.0	3,182	7.4	6.84	3.4	112	3.6	147.99	0.7	27	18.5	22.96	8.2	171															

1/ Includes miscellaneous services, such as ambulance services and rental of durable medical equipment, and services of unknown type not shown separately.

2/ Less than 25 services in sample.

2/ Less than 0.05 percent

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1	14	8	5	2	10	1	2
2	14	2	2	14	11	2	1
3	14	1	4	14	11	2	1
4	14	2	5	14	11	2	1
5	14	2	5	14	11	2	1
6	14	2	5	14	11	2	1
7	14	2	5	14	11	2	1
8	14	2	5	14	11	2	1
9	14	2	5	14	11	2	1
10	14	2	5	14	11	2	1
11	14	2	5	14	11	2	1
12	14	2	5	14	11	2	1
13	14	2	5	14	11	2	1
14	14	2	5	14	11	2	1
15	14	2	5	14	11	2	1
16	14	2	5	14	11	2	1
17	14	2	5	14	11	2	1
18	14	2	5	14	11	2	1
19	14	2	5	14	11	2	1
20	14	2	5	14	11	2	1
21	14	2	5	14	11	2	1
22	14	2	5	14	11	2	1
23	14	2	5	14	11	2	1
24	14	2	5	14	11	2	1
25	14	2	5	14	11	2	1
26	14	2	5	14	11	2	1
27	14	2	5	14	11	2	1
28	14	2	5	14	11	2	1
29	14	2	5	14	11	2	1
30	14	2	5	14	11	2	1
31	14	2	5	14	11	2	1
32	14	2	5	14	11	2	1
33	14	2	5	14	11	2	1
34	14	2	5	14	11	2	1
35	14	2	5	14	11	2	1
36	14	2	5	14	11	2	1
37	14	2	5	14	11	2	1
38	14	2	5	14	11	2	1
39	14	2	5	14	11	2	1
40	14	2	5	14	11	2	1
41	14	2	5	14	11	2	1
42	14	2	5	14	11	2	1
43	14	2	5	14	11	2	1
44	14	2	5	14	11	2	1
45	14	2	5	14	11	2	1
46	14	2	5	14	11	2	1
47	14	2	5	14	11	2	1
48	14	2	5	14	11	2	1
49	14	2	5	14	11	2	1
50	14	2	5	14	11	2	1
51	14	2	5	14	11	2	1
52	14	2	5	14	11	2	1
53	14	2	5	14	11	2	1
54	14	2	5	14	11	2	1
55	14	2	5	14	11	2	1
56	14	2	5	14	11	2	1
57	14	2	5	14	11	2	1
58	14	2	5	14	11	2	1
59	14	2	5	14	11	2	1
60	14	2	5	14	11	2	1
61	14	2	5	14	11	2	1
62	14	2	5	14	11	2	1
63	14	2	5	14	11	2	1
64	14	2	5	14	11	2	1
65	14	2	5	14	11	2	1
66	14	2	5	14	11	2	1
67	14	2	5	14	11	2	1
68	14	2	5	14	11	2	1
69	14	2	5	14	11	2	1
70	14	2	5	14	11	2	1
71	14	2	5	14	11	2	1
72	14	2	5	14	11	2	1
73	14	2	5	14	11	2	1
74	14	2	5	14	11	2	1
75	14	2	5	14	11	2	1
76	14	2	5	14	11	2	1
77	14	2	5	14	11	2	1
78	14	2	5	14	11	2	1
79	14	2	5	14	11	2	1
80	14	2	5	14	11	2	1
81	14	2	5	14	11	2	1
82	14	2	5	14	11	2	1
83	14	2	5	14	11	2	1
84	14	2	5	14	11	2	1
85	14	2	5	14	11	2	1
86	14	2	5	14	11	2	1
87	14	2	5	14	11	2	1
88	14	2	5	14	11	2	1
89	14	2	5	14	11	2	1
90	14	2	5	14	11	2	1
91	14	2	5	14	11	2	1
92	14	2	5	14	11	2	1
93	14	2	5	14	11	2	1
94	14	2	5	14	11	2	1
95	14	2	5	14	11	2	1
96	14	2	5	14	11	2	1
97	14	2	5	14	11	2	1
98	14	2	5	14	11	2	1
99	14	2	5	14	11	2	1
100	14	2	5	14	11	2	1



† Preliminary data based on 5-percent sample bills processed through August 1968.

✓ Less than 25 services in sample
✓ Less than 0.05 percent.

1871-72	1871-72
1872-73	1872-73
1873-74	1873-74
1874-75	1874-75
1875-76	1875-76
1876-77	1876-77
1877-78	1877-78
1878-79	1878-79
1879-80	1879-80
1880-81	1880-81
1881-82	1881-82
1882-83	1882-83
1883-84	1883-84
1884-85	1884-85
1885-86	1885-86
1886-87	1886-87
1887-88	1887-88
1888-89	1888-89

Table 2 - Indicators: Total number of services, percent where allowed charge less than total charge, average total charge and percent reduction from total to allowed charge by geographic division, State, carrier, and date of service, July 1967 - June 1968 (Cont'd)

/Preliminary data based on 5-percent sample bills processed through August 1968/

Geographic Division, State, Carrier and Date of Service	All Services				Medical Care				Surgery				Consultation				Diagnostic X-ray				Diagnostic Lab				Anesthesia				Asst. at Surgery			
	Number of charge services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced	Number of services	Percent where charge reduced	Average total charge	Percent reduced
Arizona (Aetna)	23,906	0.92	\$11.31	0.72	17,888	0.47	\$ 7.24	0.27	368	3.27	\$131.39	1.27	264	2.27	\$23.82	0.47	1,028	0.92	\$13.56	0.57	3,384	2.62	\$ 5.82	1.27	163	8.02	\$66.10	1.67	52	17.32	\$73.13	4.77
January-June 1967	13,946	1.9	13.58	1.0	10,538	1.2	8.55	0.7	352	6.0	150.82	1.4	185	2.7	28.26	0.8	712	0.8	13.72	1.7	1,638	5.9	6.48	2.8	109	6.4	79.60	0.7	45	22.2	73.71	5.5
January-June 1968																																
Utah (B/S)	6,897	10.5	12.04	3.9	5,113	8.4	6.31	2.5	247	22.3	131.86	6.5	60	3.3	23.23	1.0	511	4.1	11.45	2.7	704	1.8	4.26	1.2	40	1.7	60.18	0.7	60	1.7	60.18	0.7
January-June 1967	2,924	7.3	15.00	2.8	2,013	9.0	7.10	2.7	122	14.8	149.99	4.1	31	0.0	21.26	0.0	216	2.8	12.97	2.2	348	1.7	4.62	0.9	40	0.0	71.50	0.0	60	0.0	71.50	0.0
January-June 1968																																
Nevada (Aetna)	2,969	0.6	12.91	0.5	2,492	0.4	8.49	0.1	44	0.0	210.48	0.7	29	0.0	25.31	0.0	121	0.0	12.76	0.0	202	1.5	8.30	0.2	60	1.7	60.18	0.7	60	1.7	60.18	0.7
January-June 1967	1,621	2.0	15.79	0.6	1,347	1.5	8.00	0.9	31	3.2	287.71	0.1	29	0.0	25.31	0.0	85	1.2	14.06	0.1	78	7.7	9.27	2.3	60	1.7	60.18	0.7	60	1.7	60.18	0.7
January-June 1968																																
Pacific																																
Washington (B/S)	45,133	5.6	10.39	2.1	30,799	5.7	6.46	2.0	1,142	7.9	109.31	2.4	343	6.4	19.79	2.2	2,445	3.8	14.64	1.4	8,385	5.4	5.21	1.9	244	21.7	59.41	2.8	166	12.3	40.45	3.6
January-June 1967	22,153	6.1	11.65	2.3	14,783	6.3	7.02	1.9	565	9.9	129.41	2.4	172	12.2	21.51	2.8	1,385	4.3	15.22	2.0	4,125	7.5	5.69	4.6	129	30.2	66.93	4.0	70	15.7	67.93	9.8
January-June 1968																																
Oregon (Aetna) 2/	30,118	0.2	9.75	0.1	21,043	0.1	6.12	0.0	847	0.6	93.49	0.2	206	0.5	21.43	0.6	1,784	0.2	11.41	0.0	5,042	0.5	4.89	0.2	185	0.5	56.77	0.5	107	0.0	61.95	0.0
January-June 1967	14,850	0.3	11.74	0.2	10,383	0.3	6.59	0.2	426	0.2	132.61	0.2	127	0.0	21.39	0.1	904	0.2	11.94	0.2	2,376	0.5	5.14	0.0	110	0.0	67.78	0.0	64	0.0	61.40	0.0
January-June 1968																																
California (B/S)	196,902	4.7	11.74	2.0	146,737	4.9	7.92	2.0	4,986	6.2	113.13	2.1	1,862	7.4	27.65	2.5	6,776	3.9	17.54	1.4	30,762	3.2	6.04	1.3	922	9.5	70.01	2.2	543	12.2	83.27	3.7
January-June 1967	75,968	8.2	13.99	2.8	52,854	8.5	8.44	3.0	2,185	11.8	134.83	2.7	782	13.7	29.95	3.9	3,230	5.2	19.04	2.0	13,089	6.8	6.41	3.8	466	15.2	73.98	3.2	284	10.9	84.85	3.2
January-June 1968																																
Occidental)	99,712	11.3	16.54	4.7	68,617	11.6	9.53	5.2	2,857	12.1	136.76	4.2	1,227	13.2	31.44	3.7	3,604	10.5	20.60	4.2	19,538	10.4	6.80	3.4	686	21.0	78.72	5.3	373	32.2	103.28	9.8
January-June 1967	35,532	13.7	18.91	4.3	22,839	15.7	10.96	4.8	1,289	12.3	182.16	3.9	539	13.7	35.24	2.5	1,580	9.6	20.41	3.0	7,430	9.5	7.34	3.4	352	21.9	78.30	4.7	202	23.8	98.39	8.7
January-June 1968																																
Hawaii (Aetna)	5,236	3.2	9.18	1.8	4,216	3.3	6.45	1.4	108	11.1	99.91	3.8	30	10.0	24.80	1.5	218	1.8	15.98	0.6	534	1.1	5.44	0.4	25	0.0	66.68	0.0	60	1.7	60.18	0.7
January-June 1967	2,023	6.5	10.28	2.0	1,607	7.3	7.04	2.1	46	13.0	92.26	1.2	30	10.0	24.80	1.5	111	1.8	12.65	0.6	197	1.0	5.77	0.5	25	0.0	66.68	0.0	60	1.7	60.18	0.7
January-June 1968																																
Other Carriers																																
Puerto Rico (B/S)	8,863	4.8	15.30	4.7	6,511	3.1	9.02	1.6	244	23.8	171.64	8.6	271	5.2	14.10	3.4	399	11.0	19.77	10.2	857	10.6	10.21	4.1	69	27.5	64.23	6.9	10	60.0	86.30	14.8
January-June 1967	3,324	6.3	15.29	6.6	2,620	5.0	9.64	2.1	88	34.1	197.44	13.0	45	10.6	13.33	4.6	105	12.4	14.98	2.7	339	6.2	8.55	5.0	17	23.5	76.88	15.6	1	100.0	125.00	72.0
January-June 1968																																
Travelers & J/	93,661	0.8	8.80	0.9	70,777	0.7	6.10	1.0	1,750	2.8	111.83	0.9	1,088	0.6	16.47	0.4	3,691	0.7	13.32	0.3	13,991	1.1	5.05	0.2	372	2.7	49.71	1.2	45	8.9	57.40	3.5
January-June 1967	36,550	1.1	9.20	0.8	29,518	1.0	6.22	0.3	621	4.2	143.57	1.2	321	0.3	18.09	0.2	1,499	0.7	11.40	0.4	3,693	1.2	4.88	1.0	130	6.9	54.22	2.1	27	22.2	30.44	8.4
January-June 1968																																
Railroad Retirement (Travelers)	84,977	0.7	10.06	0.9	67,690	0.6	6.70	0.6	2,080	3.6	110.32	1.5	765	2.4	21.18	1.1	2,584	0.7	13.50	0.4	8,905	0.5	5.32	0.6	410	4.6	54.94	1.6	110	7.3	63.59	2.7
January-June 1967	21,979	0.9	12.35	1.0	17,388	0.8	7.34	0.3	604	4.1	144.89	1.9	230	2.2	22.56	0.8	801	0.7	13.75	1.5	2,064	0.9	5.82	2.1	160	3.1	57.50	0.9	47	2.1	62.38	0.8
January-June 1968																																
Equitable & J/	1,346	0.4	9.13	0.1	1,080	0.4	5.93	0.2	60	6.0	60.00	0.2	60	6.0	60.00	0.2	38	0.0	10.68	0.0	147	0.0	3.78	0.0	60	1.7	60.18	0.7	60	1.7	60.18	0.7
January-June 1967	843	1.2	9.69	0.3	508	1.2	6.25	0.5	60	6.0	60.00	0.2	60	6.0	60.00	0.2	38	0.0	10.68	0.0	147	0.0	3.78	0.0	60	1.7	60.18	0.7	60	1.7	60.18	0.7
January-June 1968																																

6/ Less than 25 services in sample.

7/ Includes small number of cases for Alaska.

8/ Includes cases for States of Minnesota, Mississippi, and Virginia not reported separately.

9/ Includes cases for States of Idaho, New Mexico, Tennessee, and Wyoming not reported separately.

5. (h) Please rank each of the carriers on the basis of * * * number of visits in calendar year 1967 by SSA central office personnel to the carrier.

Enclosed is a list of carrier service areas for which the number of visits by SSA central office staff in calendar year 1967 are shown. It is apparent from the range of the number of such visits (from zero to 8 for 65 service areas) that ranking of the carriers would not be appropriate. However, the following table summarizes the data in the listing:

Number of visits	Offices visited	Total visits
0-----	11-----	11-----
1-----	15-----	15-----
2-----	15-----	30-----
3-----	6-----	18-----
4-----	4-----	16-----
5-----	6-----	30-----
6-----	5-----	30-----
7-----	1-----	7-----
8-----	2-----	16-----
Total-----	65-----	162-----

Thus, 162 visits were made to 54 carrier offices (and none to 11 other offices) by SSA central office personnel in 1967. These figures, however, do not reflect the frequent visits made by personnel from the regional health insurance offices to carrier offices. As indicated in the earlier reply to question 2, all carriers have been visited and evaluated by regional office staff and/or central office staff, with first priority given to visits to carriers having the greatest difficulty in performing under their contracts. (Contract performance reviews by SSA central office staff have now been completed for every carrier.)

Visits to carrier offices by central office staff of the Social Security Administration, calendar year 1967

State	Carrier	Visits by central office staff in 1967
Alabama-----	Blue Shield-----	2-----
Alaska-----	Aetna-----	1-----
Arizona-----	do-----	2-----
Arkansas-----	Blue Shield-----	0-----
California-----	do-----	6-----
	Occidental-----	2-----
Colorado-----	Blue Shield-----	2-----
Connecticut-----	Connecticut General-----	4-----
Delaware-----	Blue Shield-----	3-----
District of Columbia-----	do-----	4-----
Florida-----	do-----	8-----
Georgia-----	John Hancock-----	5-----
Hawaii-----	Aetna-----	1-----
Idaho-----	Equitable-----	0-----
Illinois-----	Blue Shield-----	5-----
	Continental Casualty-----	2-----
Indiana-----	Blue Shield-----	2-----
Iowa-----	do-----	6-----

See footnotes at end of table, p. 306.

Visits to carrier offices by central office staff of the Social Security Administration, calendar year 1967—Continued

State	Carrier	Visits by central office staff in 1967
Kansas	Blue Shield of Topeka	0
	Blue Shield of Kansas City, Mo.	1
Kentucky	Metropolitan	2
Louisiana	Pan American	2
Maine	Union Mutual	2
Maryland	Blue Shield of Maryland	2
	District of Columbia Blue Shield	(1)
Massachusetts	Blue Shield	7
Michigan	do	5
Minnesota	do	3
	Travelers	1
Mississippi	do	1
Missouri	Blue Shield	1
	General American	3
Montana	Blue Shield	0
Nebraska	Mutual of Omaha	3
Nevada	Aetna	0
New Hampshire	Blue Shield	1
New Jersey	Prudential	8
New Mexico	Equitable	0
New York	Blue Shield of Buffalo	5
	Blue Shield of New York City	3
	Blue Shield of Rochester	2
	Metropolitan	5
	Group Health	5
North Carolina	Pilot Life	4
North Dakota	Blue Shield	1
Ohio	Nationwide	6
	Blue Shield of Cleveland	1
Oklahoma	Aetna	2
	Department of Welfare	1
Oregon	Aetna	1
Pennsylvania	Blue Shield	6
Rhode Island	do	4
South Carolina	do	1
South Dakota	do	1
Tennessee	Equitable	0
Texas	Blue Shield	6
Utah	do	0
Vermont	do	2
Virginia	Travelers	1
	District of Columbia Blue Shield	(1)
Washington	Blue Shield	3
West Virginia	Nationwide	1
Wisconsin	Blue Shield of Madison	2
	Blue Shield of Milwaukee	0
Wyoming	Equitable	0
Puerto Rico	Blue Shield	0
Virgin Islands	Mutual of Omaha	2
Railroad	Travelers	(2)
	SSA	(3)

¹ Included in visits shown for District of Columbia.

² A number of visits were made to this carrier office, but no formal count was maintained.

³ Not applicable.

5. (i) *Please rank each of the carriers on the basis of * * * proportion of carrier administrative costs ascribed to salaries of carrier personnel for last quarter of 1967.*

Enclosed is a table presenting, for each carrier, personnel costs as a percentage of total administrative expenses. The data are given for both the last calendar quarter of 1967, as requested, and for the fiscal year ending June 30, 1968. The latter are offered as being more representative than quarterly data which are subject to seasonal fluctuations and short-term abnormalities in spending patterns.

Although the data have been ranked as requested and the lowest proportion of personnel costs is ranked first, it is questionable whether the rankings relate to efficiency of performance.

There is, of course, an inverse relationship between the number of man-hours per claim processed and the extent to which claims review has been automated. The substitution of machines for personnel may not in every instance reduce total costs but always reduces the ratio of personnel to total costs. Since a number of factors determine both whether and how much the claims review process should be automated (perhaps the most important of which is the volume of claims handled), the optimum ratio of personnel costs to total costs necessarily would vary from carrier to carrier.

Consideration must also be given to variation over time in non-labor expenditures—particularly large, one-time or short-term outlays. Such costs include, but are not limited to, those associated with moving or renovating quarters, investment of capital in equipment, and large-scale training programs.

Carrier personnel expenses as a proportion of total carrier medicare administrative expenses, October–December 1967 and fiscal year 1968

State	Carrier	October–December 1967		Fiscal year 1968	
		Personnel costs as a percent of administrative costs	Rank ¹	Personnel costs as a percent of administrative costs	Rank ²
Alabama	Blue Shield	65.3	27	63.5	18
Alaska	Aetna	(³)	-----	(³)	-----
Arizona	do	(³)	-----	(³)	-----
Arkansas	Blue Shield	70.5	37	66.5	27
California	do	58.5	12	65.4	22
	Occidental	77.0	49	73.7	47
Colorado	Blue Shield	64.3	23	66.0	25
Connecticut	Connecticut General	75.7	48	73.5	46
Delaware	Blue Shield	70.7	39	71.9	43
District of Columbia	do	(³)	-----	(³)	-----
Florida	do	59.5	14	59.7	9
Georgia	John Hancock	70.6	38	68.7	35
Hawaii	Aetna	(³)	-----	(³)	-----
Idaho	Equitable	(³)	-----	(³)	-----
Illinois	Blue Shield	61.0	15	59.6	8
	Continental Casualty	68.8	33	68.0	32
Indiana	Blue Shield	64.3	23	67.3	30
Iowa	do	53.0	4	61.6	13
Kansas	Blue Shield of Topeka	57.1	7	66.0	26
	Blue Shield of Kansas City, Missouri	(³)	-----	(³)	-----
Kentucky	Metropolitan	(³)	-----	(³)	-----
Louisiana	Pan American	82.4	50	77.0	51
Maine	Union Mutual	64.1	22	67.7	31
Maryland	Blue Shield of Maryland	67.9	31	68.1	33
	District of Columbia Blue Shield	(³)	-----	(³)	-----
Massachusetts	Blue Shield	57.8	8	61.2	12
Michigan	do	68.6	32	64.8	21
Minnesota	do	61.7	16	58.6	6
	Travelers	(³)	-----	(³)	-----
Mississippi	do	(³)	-----	(³)	-----
Missouri	Blue Shield	(³)	-----	(³)	-----
	Gen. American	70.4	36	67.2	29
Montana	Blue Shield	61.8	18	63.2	17
Nebraska	Mutual of Omaha	(³)	-----	(³)	-----
Nevada	Aetna	(³)	-----	(³)	-----
New Hampshire	Blue Shield	(³)	-----	(³)	-----
New Jersey	Prudential	72.1	43	74.1	48
New Mexico	Equitable	(³)	-----	(³)	-----
New York	Blue Shield of Buffalo	58.0	9	58.6	5
	Blue Shield of New York City	64.8	25	69.2	36
	Blue Shield of Rochester	61.7	16	59.1	7
	Metropolitan Group Health	(³)	-----	(³)	-----
North Carolina	Pilot Life	63.9	21	65.6	23
North Dakota	Blue Shield	72.5	44	74.2	49
		52.3	3	55.4	4

See footnotes at end of table, p. 309.

Carrier personnel expenses as a proportion of total carrier medicare administrative expenses, October-December 1967 and fiscal year 1968—Continued

State	Carrier	October-December 1967		Fiscal year 1968	
		Personnel costs as a percent of administrative costs	Rank ¹	Personnel costs as a percent of administrative costs	Rank ²
Ohio-----	Nationwide-----	(³)	-----	(³)	-----
	Blue Shield of Cleveland.	58. 4	10	61. 8	14
Oklahoma-----	Aetna-----	(³)	-----	(³)	-----
	Department of Welfare.	73. 5	46	70. 5	37
Oregon-----	Aetna-----	(³)	-----	(³)	-----
Pennsylvania-----	Blue Shield-----	69. 9	34	68. 4	34
Rhode Island-----	do-----	67. 6	30	62. 0	15
South Carolina-----	do-----	58. 4	10	60. 0	11
South Dakota-----	do-----	46. 7	2	51. 8	3
Tennessee-----	Equitable-----	(³)	-----	(³)	-----
Texas-----	Blue Shield-----	58. 5	12	44. 1	2
Utah-----	do-----	70. 3	35	63. 5	19
Vermont-----	do-----	(³)	-----	(³)	-----
Virginia-----	Travelers-----	(³)	-----	(³)	-----
	District of Columbia Blue Shield.	(³)	-----	(³)	-----
Washington ⁴ -----	Blue Shield-----	65. 2	26	63. 1	16
West Virginia-----	Nationwide-----	(³)	-----	(³)	-----
Wisconsin-----	Blue Shield of Madison.	66. 1	28	65. 7	24
	Blue Shield of Milwaukee.	32. 9	1	36. 3	1
Wyoming-----	Equitable-----	(³)	-----	(³)	-----
Puerto Rico-----	Blue Shield-----	62. 4	19	71. 4	40
Virgin Islands-----	Mutual of Omaha-----	(³)	-----	(³)	-----
Railroad-----	Travelers-----	(³)	-----	73. 4	44
	Aetna ⁵ -----	71. 5	41	74. 5	50
	District of Columbia Blue Shield. ⁶	72. 5	44	71. 6	42
	Equitable ⁷ -----	62. 8	20	70. 7	38
	Blue Shield of Kansas City, Mo. ⁸	71. 5	41	71. 2	39
	Metropolitan ⁹ -----	74. 1	47	73. 4	45
	Travelers (except RRB). ¹⁰	¹¹ 66. 9	29	¹² 67. 1	28
	Mutual of Omaha ¹³ -----	56. 8	6	59. 9	10
	New Hampshire-Vermont Blue Shield.	54. 0	5	63. 7	20
	Nationwide ¹⁴ -----	71. 1	40	71. 5	41

¹ Rankings based on 50 carriers.

² Rankings based on 51 carriers, counting Travelers' service of railroad retirement annuitants as a separate entity.

³ Data for separate components of multi-State carriers not available; personnel costs as a percentage of total administrative costs for total operations of such carriers are shown at end of table.

⁴ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁵ Aetna has separate service areas in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon.

⁶ District of Columbia Blue Shield has separate service areas in the District of Columbia, Maryland, and Virginia.

⁷ Equitable has separate service areas in Idaho, New Mexico, Tennessee, and Wyoming.

⁸ Blue Shield of Kansas City, Mo., has separate service areas in Kansas and Missouri.

⁹ Metropolitan has separate service areas in Kentucky and New York.

¹⁰ Travelers has separate service areas in Minnesota, Mississippi, and Virginia.

¹¹ Includes costs of services to railroad retirement annuitants.

¹² Excludes costs of services to railroad retirement annuitants.

¹³ Mutual of Omaha has separate service areas in Nebraska and the Virgin Islands.

¹⁴ Nationwide has separate service areas in Ohio and West Virginia.

5. (j) *Please rank each of the carriers on the basis of * * * proportion of carrier administrative costs ascribed to fixed assets of carrier for last quarter of 1967.*

5. (k) *Please rank each of the carriers on the basis of * * * proportion of carrier administrative costs ascribed to other assets for last quarter of 1967.*

No reply to questions 5(j) and 5(k) is possible without taking a special survey of the carriers and requiring them to establish costs on a basis different from that now specified. Carriers are required to report administrative expenses on a functional basis rather than on an account basis so that management—both carrier and SSA—can isolate the particular operations within carriers' systems which require special attention. Thus, for example, the effectiveness of the professional relations programs of several carriers may be related to the cost of each program (i.e., hospital insurance and medical insurance), and meaningful management decisions can be made with respect to efficiency, need for increased emphasis, etc. Functional cost reporting emphasizes the relevance of carrier budgets: budgets are management plans, agreed to by SSA through the approval process, to perform specified functions at a stipulated cost. The only account-type reporting required of carriers is the distinction between personal service costs and all other costs.

5. (l) *Please rank each of the carriers on the basis of * * * proportion of carrier administrative costs ascribed to other expenses for last quarter of 1967.*

Enclosed is a table presenting, for each carrier, costs other than personnel expenses as a percentage of total administrative expenditures. The data are given for both the last calendar quarter of 1967, as requested, and for the fiscal year ending June 30, 1968. The latter are offered as being more representative than quarterly data which are subject to seasonal fluctuations and short-term abnormalities in spending patterns.

The proportions are, of course, the difference between 100.0% and the personnel costs as a percent of administrative costs. (For example, for the last quarter of 1967, Alabama Blue Shield shows a 34.7% figure in the enclosed table, while the comparable figure in the table submitted in response to question 5(i) shows 65.3%.) This is so because the components of administrative costs requested in questions 5(j) and 5(k) are unavailable, as previously explained. Thus, those components are included in the proportions shown in the enclosed table.

It will be noted that the rankings in the enclosed table and the table responding to question 5(i) are identical. Since the data on personnel costs as a proportion of total costs were ranked so that the lowest proportion of personnel costs were ranked first, the same ranking was used for this table. Thus, a low ratio of personnel costs is ranked first and a high ratio of non-personnel costs is also ranked first.

Proportion of carrier administrative costs ascribed to expenses other than personnel, October-December 1967 and fiscal year 1968

State	Carrier	October-December 1967		Fiscal year 1968	
		Non- personnel costs as a percent of admin- istrative costs	Rank ¹	Non- personnel costs as a percent of admin- istrative costs	Rank ²
Alabama	Blue Shield	34. 7	27	36. 5	18
Alaska	Aetna	(3)	-----	(3)	-----
Arizona	do	(3)	-----	(3)	-----
Arkansas	Blue Shield	29. 5	37	33. 5	27
California	do	41. 5	12	34. 6	22
	Occidental	23. 0	49	26. 3	47
Colorado	Blue Shield	35. 7	23	34. 0	25
Connecticut	Conn. General	24. 3	48	26. 5	46
Delaware	Blue Shield	29. 3	39	28. 1	43
District of Columbia	do	(3)	-----	(3)	-----
Florida	do	40. 5	14	40. 3	9
Georgia	John Hancock	29. 4	38	31. 3	35
Hawaii	Aetna	(3)	-----	(3)	-----
Idaho	Equitable	(3)	-----	(3)	-----
Illinois	Blue Shield	39. 0	15	40. 4	8
	Continental	31. 2	33	32. 0	32
	Casualty.				
Indiana	Blue Shield	35. 7	23	32. 7	30
Iowa	do	47. 0	4	38. 4	13
Kansas	Blue Shield of Topeka.	42. 9	7	34. 0	26
	Blue Shield of Kansas City, Mo.	(3)	-----	(3)	-----
Kentucky	Metropolitan	(3)	-----	(3)	-----
Louisiana	Pan American	17. 6	50	23. 0	51
Maine	Union Mutual	35. 9	22	32. 3	31
Maryland	Blue Shield of Maryland.	32. 1	31	31. 9	33
	District of Columbia Blue Shield.	(3)	-----	(3)	-----
Massachusetts	Blue Shield	42. 2	8	38. 8	12
Michigan	do	31. 4	32	35. 2	21
Minnesota	do	38. 3	16	41. 4	6
	Travelers	(3)	-----	(3)	-----
Mississippi	do	(3)	-----	(3)	-----
Missouri	Blue Shield	(3)	-----	(3)	-----
	Gen. American	29. 6	36	32. 8	29
Montana	Blue Shield	38. 2	18	36. 8	17
Nebraska	Mutual of Omaha	(3)	-----	(3)	-----
Nevada	Aetna	(3)	-----	(3)	-----
New Hampshire	Blue Shield	(3)	-----	(3)	-----
New Jersey	Prudential	27. 9	43	25. 9	48
New Mexico	Equitable	(3)	-----	(3)	-----
New York	Blue Shield of Buffalo.	42. 0	9	41. 4	5
	Blue Shield of New York City.	35. 2	25	30. 8	36
	Blue Shield of Rochester.	38. 3	16	4. 09	7
	Metropolitan	(3)	-----	(3)	-----
	Group Health	36. 1	21	34. 4	23
North Carolina	Pilot Life	27. 5	44	25. 8	49
North Dakota	Blue Shield	47. 7	3	44. 6	4

See footnotes at end of table, p. 312.

Proportion of carrier administrative costs ascribed to expenses other than personnel, October–December 1967 and fiscal year 1968—Continued

State	Carrier	October–December 1967		Fiscal year 1968	
		Non-personnel costs as a percent of administrative costs	Rank ¹	Non-personnel costs as a percent of administrative costs	Rank ²
Ohio	Nationwide	(3)		(3)	
	Blue Shield of Cleveland	41. 6	10	38. 2	14
Oklahoma	Aetna	(3)		(3)	
	Department of Welfare	26. 5	46	29. 5	37
Oregon	Aetna	(3)		(3)	
Pennsylvania	Blue Shield	30. 1	34	31. 6	34
Rhode Island	do.	32. 4	30	38. 0	15
South Carolina	do.	41. 6	10	40. 0	11
South Dakota	do.	53. 3	2	48. 2	3
Tennessee	Equitable	(3)		(3)	
Texas	Blue Shield	41. 5	12	55. 9	2
Utah	do.	29. 7	35	36. 5	19
Vermont	do.	(3)		(3)	
Virginia	Travelers	(3)		(3)	
	Dist. of Col. Blue Shield	(3)		(3)	
Washington ⁴	Blue Shield	34. 8	26	36. 9	16
West Virginia	Nationwide	(3)		(3)	
Wisconsin	Blue Shield of Madison	33. 9	28	34. 3	24
	Blue Shield of Milwaukee	67. 1	1	63. 7	1
Wyoming	Equitable	(3)		(3)	
Puerto Rico	Blue Shield	37. 6	19	28. 6	40
Virgin Islands	Mutual of Omaha	(3)		(3)	
Railroad	Travelers	(3)		26. 6	44
	Aetna ⁵	28. 5	41	25. 5	50
	Dist. of Col. Blue Shield ⁶	27. 5	44	28. 4	42
	Equitable ⁷	37. 2	20	29. 3	38
	Blue Shield of K.C., Mo. ⁸	28. 5	41	28. 8	39
	Metropolitan ⁹	25. 9	47	26. 6	45
	Travelers (except RRB) ¹⁰	¹¹ 33. 1	29	¹² 32. 9	28
	Mutual of Omaha ¹³	43. 2	6	40. 1	10
	N.H.-Vt. Blue Shield	46. 0	5	36. 3	20
	Nationwide ¹⁴	28. 9	40	28. 5	41

¹ Rankings based on 50 carriers.

² Rankings based on 51 carriers, counting Travelers' service of Railroad Retirement annuitants as a separate entity.

³ Data for separate components of multi-State carriers not available; nonpersonnel costs as a percentage of total administrative costs for total operations of such carriers are shown at end of table.

⁴ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁵ Aetna has separate service areas in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon.

⁶ District of Columbia Blue Shield has separate service areas in the District of Columbia, Maryland, and Virginia.

⁷ Equitable has separate service areas in Idaho, New Mexico, Tennessee, and Wyoming.

⁸ Blue Shield of Kansas City, Missouri, has separate service areas in Kansas and Missouri.

⁹ Metropolitan has separate service areas in Kentucky and New York.

¹⁰ Travelers has separate service areas in Minnesota, Mississippi, and Virginia.

¹¹ Includes costs of services to Railroad Retirement annuitants.

¹² Excludes costs of services to Railroad Retirement annuitants.

¹³ Mutual of Omaha has separate service areas in Nebraska and the Virgin Islands.

¹⁴ Nationwide has separate service areas in Ohio and West Virginia.

5. (m) *Please rank each of the carriers on the basis of * * * total benefit disbursements and total administrative costs allowed for calendar year 1967 (computed on a comparable basis, actual or accrued).*

The enclosed table shows the dollar amounts actually expended in calendar year 1967 by each carrier for benefit payments and administrative costs under the medical insurance program. The ratio of administrative costs to benefit payments has been computed and the carriers have been ranked by this performance indicator.

It should be noted, however, that the relationship between administrative costs and benefit payments is not an ideal criterion by which to judge the carriers' performance. For example, as indicated in other parts of the response to question 5, the extent of automation in a carrier's operation affects its unit costs (which, of course, is a function of total administrative costs), thereby affecting the ratio of such costs to benefit payments. The ratio is also a function of a variety of variables including efficiency of performance, proportion of assigned bills received, level of training of employees, local wage scales, etc. (These factors were discussed in some detail in response to question 5(d).)

Benefit payments and administrative costs of carriers, calendar year 1967 ¹

State	Carrier	Benefit payments	Administrative costs	Ratio of administrative costs to benefit payments	
				Percent	Rank ²
Alabama	Blue Shield	\$11,550,891	\$677,504	5.87	5
Alaska	Aetna	(3)	(3)	(3)	—
Arizona	do	(3)	(3)	(3)	—
Arkansas	Blue Shield	8,334,245	554,265	6.65	10
California	do	109,747,903	7,709,413	6.57	8
	Occidental	62,679,270	4,122,636	6.58	9
	Blue Shield	13,851,185	1,231,515	8.89	34
Colorado	Connecticut General	17,800,629	1,063,401	5.97	6
Connecticut	Blue Shield	2,133,779	335,900	15.74	51
Delaware	do	(3)	(3)	(3)	—
District of Columbia	do	62,337,272	3,618,705	5.81	4
Florida	John Hancock	13,564,244	1,672,597	12.33	50
Georgia	Aetna	(3)	(3)	(3)	—
Hawaii	Equitable	(3)	(3)	(3)	—
Idaho	Blue Shield	29,016,578	2,295,238	7.91	23
Illinois	Continental Casualty	17,090,240	1,480,012	8.66	31
	Blue Shield	19,170,027	1,544,656	8.06	24
Indiana	do	16,066,030	1,222,835	7.61	20
Iowa	Blue Shield of Topeka	8,452,651	692,117	8.19	25
Kansas	Blue Shield of Kansas City, Mo.	(3)	(3)	(3)	—
Kentucky	Metropolitan	(3)	(3)	(3)	—
Louisiana	Pan American	11,133,159	1,091,947	9.81	41
Maine	Union Mutual	4,719,294	495,405	10.50	46
Maryland	Blue Shield of Maryland	8,964,868	910,653	10.16	42
	District of Columbia Blue Shield	(3)	(3)	(3)	—
Massachusetts	Blue Shield	39,920,148	3,025,514	7.58	19
Michigan	do	35,602,872	3,053,239	8.58	28
Minnesota	do	6,849,761	697,648	10.18	43
	Travelers	(3)	(3)	(3)	—
Mississippi	do	(3)	(3)	(3)	—
Missouri	Blue Shield	(3)	(3)	(3)	—

See footnotes at end of table, p. 316.

Montana-----	General American-----	16, 677, 310	1, 124, 575	6. 74	13
Nebraska-----	Blue Shield-----	3, 406, 783	302, 769	8. 89	33
Nevada-----	Mutual of Omaha-----	(3)	(3)	(3)	---
New Hampshire-----	Actna-----	(3)	(3)	(3)	---
New Jersey-----	Blue Shield-----	(3)	(3)	(3)	---
New Mexico-----	Prudential-----	(3)	(3)	(3)	---
New York-----	Equitable-----	43, 023, 500	2, 433, 300	5. 66	2
	Blue Shield of Buffalo-----	(3)	(3)	(3)	---
	Blue Shield of New York City-----	7, 675, 194	835, 180	10. 88	48
	Blue Shield of Rochester-----	84, 667, 291	6, 498, 692	7. 68	22
	Metropolitan-----	4, 367, 324	445, 457	10. 20	44
	Group Health-----	(3)	(3)	(3)	---
North Carolina-----	Pilot Life-----	11, 764, 809	1, 265, 002	10. 75	47
North Dakota-----	Blue Shield-----	15, 621, 718	1, 102, 800	7. 06	18
Ohio-----	Nationwide-----	3, 483, 207	292, 843	8. 41	27
	Blue Shield of Cleveland-----	(3)	(3)	(3)	---
Oklahoma-----	Actna-----	8, 682, 950	891, 040	10. 26	45
	Department of Welfare ⁴ -----	(3)	(3)	(3)	---
Oregon-----	Actna-----	3, 994, 693	267, 159	6. 69	11
Pennsylvania-----	Blue Shield-----	(3)	(3)	(3)	---
Rhode Island-----	do-----	57, 395, 611	3, 243, 825	5. 65	1
South Carolina-----	do-----	5, 630, 638	525, 613	9. 33	37
South Dakota-----	do-----	6, 153, 560	418, 589	6. 80	14
Tennessee-----	Equitable-----	3, 407, 292	234, 605	6. 89	15
Texas-----	Blue Shield-----	(3)	(3)	(3)	---
Utah-----	do-----	57, 597, 827	3, 879, 909	6. 74	12
Vermont-----	do-----	1, 581, 871	136, 968	8. 66	30
Virginia-----	Travelers-----	(3)	(3)	(3)	---
	District of Columbia-----	(2)	(2)	(2)	---
Washington ⁵ -----	Blue Shield-----	18, 576, 168	2, 040, 694	10. 99	49
West Virginia-----	Nationwide-----	(3)	(3)	(3)	---
Wisconsin-----	Blue Shield of Madison-----	14, 510, 727	1, 355, 978	9. 34	38
	Blue Shield of Milwaukee-----	6, 167, 833	584, 169	9. 47	40
Wyoming-----	Equitable-----	(3)	(3)	(3)	---
Puerto Rico-----	Blue Shield-----	3, 679, 033	211, 266	5. 74	3
Virgin Islands-----	Mutual of Omaha-----	(3)	(3)	(3)	---
Railroad-----	Travelers ⁶ -----	45, 987, 481	3, 777, 210	8. 21	26

Benefit payments and administrative costs of carriers, calendar year 1967¹—Continued

State	Carrier	Benefit payments	Administrative costs	Ratio of administrative costs to benefit payments	
				Percent	Rank ²
Railroad—Continued	Aetna ⁷	42,485,463	2,925,489	6.89	16
	District of Columbia Blue Shield ⁸	8,782,927	769,331	8.76	32
	Equitable ⁹	24,064,828	1,832,723	7.62	21
	Blue Shield of Kansas City, Mo. ¹⁰	9,464,691	864,774	9.14	35
	Metropolitan ¹¹	32,362,311	2,798,497	8.65	29
	Travelers (except RRB) ¹²	38,003,000	2,458,000	6.47	7
	Mutual of Omaha ¹³	8,437,489	592,956	7.03	17
	New Hampshire-Vermont Blue Shield	5,846,316	552,554	9.45	39
	Nationwide ¹⁴	35,722,499	3,315,408	9.28	36

¹ All dollar amounts subject to adjustment following audit by DHEW.

² Rankings based on 51 carriers, counting Travelers' service of railroad retirement annuitants as a separate entity.

³ Data for separate components of multistate carriers not available; data for total operations of such carriers are shown at end of table.

⁴ Includes expenditures only for the period of July-December 1967; carrier not under contract for the full year.

⁵ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁶ Travelers' service of railroad retirement annuitants treated as separate carrier entity.

⁷ Aetna has separate service areas in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon.

⁸ District of Columbia Blue Shield has separate service areas in the District of Columbia, Maryland, and Virginia.

⁹ Equitable has separate service areas in Idaho, New Mexico, Tennessee, and Wyoming.

¹⁰ Blue Shield of Kansas City, Mo., has separate service areas in Kansas and Missouri.

¹¹ Metropolitan has separate service areas in Kentucky and New York.

¹² Travelers has separate service areas in Minnesota, Mississippi, and Virginia.

¹³ Mutual of Omaha has separate service areas in Nebraska and the Virgin Islands.

¹⁴ Nationwide has separate service areas in Ohio and West Virginia.

5. (n) Please rank each of the carriers on the basis of * * * salaries of head of Medicare operations—most recent data possible.

The table enclosed presents the salaries of the individuals designated by each of the carriers as being in charge of Medicare operations. As with other items, the salaries have been assigned rankings as requested, but there are substantial questions about the validity of such rankings.

Some salaries include compensation for services related to the private business of each of the carriers and some carriers pay a single salary to the heads of their Medicare operations who direct a number of non-private-business functions. Where applicable, the individual may be paid to direct hospital insurance intermediary operations under Medicare and title XIX (Medicaid) business in addition to the company's medical insurance carrier operations. Moreover, some companies, in reporting salaries, have included (and others have excluded) compensation for such additional services in the figures they furnished. These deviations are noted wherever possible.

Another consideration in evaluating the validity of the rankings is the magnitude and complexity of the operation being directed. For example, the head of a large organization who has responsibility for all its phases including its automated processing operation cannot be expected to receive a salary approximating that of the head of an automated carrier serving a smaller number of beneficiaries, perhaps in a single metropolitan area, who may have full responsibility only for the manual aspects of the claims process. Despite the fact that some of the salaries are overstated (as indicated in the preceding paragraph), a correlation can be established between the salary of the head of Medicare operations and the total dollar amount of benefit payments. But, statistically speaking, this correlation is not very high.

Annual salaries of carriers' heads of medicare operations

State	Carrier	Salary of heads of medicare operation	Rank ¹
Alabama	Blue Shield	² \$22, 200	11
Alaska	Aetna	(³)	-----
Arizona	do	(³)	-----
Arkansas	Blue Shield	² 11, 800	44
California	do	⁴ 16, 000	24
	Occidental	⁴ 16, 000	24
Colorado	Blue Shield	² 18, 500	17
Connecticut	Connecticut General	⁴ 18, 000	18
Delaware	Blue Shield	² 28, 000	2
District of Columbia	do	(³)	-----
Florida	do	¹ 12, 700	40
Georgia	John Hancock	¹ 17, 000	20
Hawaii	Aetna	(²)	-----
Idaho	Equitable	(³)	-----
Illinois	Blue Shield	² 19, 500	14
	Continental Casualty	⁴ 14, 500	31
Indiana	Blue Shield	⁴ 14, 100	33
Iowa	do	² 16, 500	22
Kansas	Blue Shield of Topeka	² 10, 100	47
	Blue Shield of Kansas City, Mo.	(³)	-----
Kentucky	Metropolitan	(³)	-----
Louisiana	Pan American	⁴ 13, 000	38
Maine	Union Mutual	² 14, 100	33

See footnotes at end of table, p. 318.

Annual salaries of carriers' heads of medicare operations—Continued

State	Carrier	Salary of heads of medicare operation	Rank ¹
Maryland	Blue Shield of Maryland	² 25, 500	6
District of Columbia	District of Columbia Blue Shield	(²)	-----
Massachusetts	Blue Shield	⁴ 14, 400	32
Michigan	do	^{2 5} 12, 500	41
Minnesota	do	² 16, 000	24
	Travelers	(³)	-----
Mississippi	do	(³)	-----
Missouri	Blue Shield	(³)	-----
	General American	² 15, 000	29
Montana	Blue Shield	⁴ 11, 000	45
Nebraska	Mutual of Omaha	(³)	-----
Nevada	Aetna	(³)	-----
New Hampshire	Blue Shield	(³)	-----
New Jersey	Prudential	² 24, 683	8
New Mexico	Equitable	(³)	-----
New York	Blue Shield of Buffalo	⁴ 15, 500	28
	Blue Shield of New York City	² 28, 500	1
	Blue Shield of Rochester	² 15, 000	29
	Metropolitan	(³)	-----
	Group Health	² 22, 500	10
North Carolina	Pilot Life	⁴ 9, 200	48
North Dakota	Blue Shield	² 12, 000	42
Ohio	Nationwide	(³)	-----
	Blue Shield of Cleveland	⁴ 16, 000	24
Oklahoma	Aetna	(³)	-----
	Department of Welfare	² 26, 000	4
Oregon	Aetna	(³)	-----
Pennsylvania	Blue Shield	^{2 5} 13, 500	36
Rhode Island	do	² 16, 250	23
South Carolina	do	² 12, 000	42
South Dakota	do	² 13, 200	37
Tennessee	Equitable	(³)	-----
Texas	Blue Shield	² 26, 000	4
Utah	do	² 9, 000	49
Vermont	do	(³)	-----
Virginia	Travelers	(³)	-----
	District of Columbia Blue Shield	(³)	-----
Washington ⁶	Blue Shield	10, 600	46
West Virginia	Nationwide	(³)	-----
Wisconsin	Blue Shield of Madison	⁴ 19, 000	15
	Blue Shield of Milwaukee	⁴ 8, 900	50
Wyoming	Equitable	(³)	-----
Puerto Rico	Blue Shield	² 21, 000	12
Virgin Islands	Mutual of Omaha	(³)	-----
Railroad	Travelers	(³)	-----
	Aetna	² 21, 000	13
	District of Columbia Blue Shield	² 27, 540	3
	Equitable	² 22, 900	9
	Blue Shield of Kansas City, Mo.	² 13, 000	38
	Metropolitan	² 18, 000	18
	Travelers (except RRB)	² 19, 000	15
	Mutual of Omaha	² 17, 000	20
	New Hampshire-Vermont Blue Shield	² 14, 000	35
	Nationwide	² 25, 000	7

¹ Rankings based on 50 carriers.² Has other duties; e.g., pt. A—medicare, CHAMPUS, FEGLI, private programs.³ Data do not apply to separate components of multistate carriers; salaries for heads of medicare operations of such carriers shown at end of table.⁴ 100 percent of time devoted to pt. B—medicare operations.⁵ Amount shown is portion of salary allocated to pt. B—medicare only.⁶ Data given for head of medicare operations of Washington State Blue Shield.

5. (o) *Please rank each of the carriers on the basis of * * * man-hours per claim handled.*

The enclosed table presents the average number of man-hours per paid bill processed by each carrier in the fiscal year ending June 30, 1968. As was the case for certain prior responses, data are given in terms of bills (rather than claims, as requested) because each claim submitted may include more than one bill—each of which may be processed separately. (See response to question 5(a) for a more detailed explanation.)

The data exclude from the computation the number of bills processed by the carrier for which no payment was made (for failure to meet the deductible requirement, nonenrolled status, exhaustion of benefits, etc.). However, there is no evidence to indicate that the proportion of no-payment bills processed varies significantly from carrier to carrier. Therefore, the averages shown in the table overstate the average time per bill handled, but by about the same proportion for each carrier.

The averages are computed by dividing the total number of paid bills processed by the product of the carrier's man-years and the estimated number of man-hours per year. The latter figure is an approximation (set at 1800 hours), based on a range of 1760 to 1880 effective hours of production per employee per year per carrier. It takes into account factors such as vacations, sick leave, overtime, paid holidays, etc. However, it does not take account of variations in the normal work week from carrier to carrier (some of which regularly are on a 40-hour basis, while others are on a 37½-hour basis). The 1800-hour factor was applied uniformly to all carriers.

Man-hours per paid bill processed by carriers in fiscal year 1968

State	Carrier	Man-hours per paid bill processed	Rank ¹
Alabama	Blue Shield	0. 747	28
Alaska	Aetna	(²)	-----
Arizona	do	(²)	-----
Arkansas	Blue Shield	. 599	11
California	do	. 442	2
	Occidental	. 768	31
Colorado	Blue Shield	. 782	34
Connecticut	Connecticut General	. 604	12
Delaware	Blue Shield	1. 263	51
District of Columbia	do	(²)	-----
Florida	do	. 627	15
Georgia	John Hancock	. 999	47
Hawaii	Aetna	(²)	-----
Idaho	Equitable	(²)	-----
Illinois	Blue Shield	. 678	20
	Continental Casualty	. 738	25
Indiana	Blue Shield	. 741	26
Iowa	do	. 668	18
Kansas	Blue Shield of Topeka	. 825	37
	Blue Shield of Kansas City, Mo.	(²)	-----
Kentucky	Metropolitan	(²)	-----
Louisiana	Pan American	1. 034	49
Maine	Union Mutual	. 919	43
Maryland	Blue Shield of Maryland	. 901	42
	District of Columbia Blue Shield.	(²)	-----
Massachusetts	Blue Shield	. 643	16
Michigan	do	. 531	4
Minnesota	do	. 945	45
	Travelers	(²)	-----
Mississippi	do	(²)	-----
Missouri	Blue Shield	(²)	-----
	General American	. 745	27
Montana	Blue Shield	. 828	38
Nebraska	Mutual of Omaha	(²)	-----
Nevada	Aetna	(²)	-----
New Hampshire	Blue Shield	(²)	-----
New Jersey	Prudential	. 588	9
New Mexico	Equitable	(²)	-----
New York	Blue Shield of Buffalo	1. 000	48
	Blue Shield of New York City	. 649	17
	Blue Shield of Rochester	. 578	8
	Metropolitan	(²)	-----
	Group Health	. 736	24
North Carolina	Pilot Life	. 930	44
North Dakota	Blue Shield	. 713	23
Ohio	Nationwide	(²)	-----
	Blue Shield of Cleveland	. 698	21
Oklahoma	Aetna	(²)	-----
	Department of Welfare	. 598	10
Oregon	Aetna	(²)	-----
Pennsylvania	Blue Shield	. 511	3
Rhode Island	do	. 622	14
South Carolina	do	. 552	6
South Dakota	do	. 712	22
Tennessee	Equitable	(²)	-----
Texas	Blue Shield	. 531	5
Utah	do	. 801	36

See footnotes at end of table, p. 321.

Man-hours per paid bill processed by carriers in fiscal year 1968—Con.

State	Carrier	Man-hours per paid bill processed	Rank ¹
Vermont -----	Blue Shield -----	(2) -----	
Virginia -----	Travelers -----	(2) -----	
	District of Columbia Blue Shield -----	(2) -----	
Washington -----	Blue Shield ³ -----	. 778 -----	33
West Virginia -----	Nationwide -----	(2) -----	
Wisconsin -----	Blue Shield of Madison -----	. 837 -----	40
	Blue Shield of Milwaukee -----	. 407 -----	1
Wyoming -----	Equitable -----	(2) -----	
Puerto Rico -----	Blue Shield -----	. 753 -----	29
Virgin Islands -----	Mutual of Omaha -----	(2) -----	
Railroad -----	Travelers -----	. 791 -----	35
	Aetna ⁴ -----	. 610 -----	13
	District of Columbia Blue Shield ⁵ -----	. 772 -----	32
	Equitable ⁶ -----	. 760 -----	30
	Blue Shield of Kansas City, Mo. ⁷ -----	1. 158 -----	50
	Metropolitan ⁸ -----	. 831 -----	39
	Travelers (except RRB) ⁹ -----	. 670 -----	19
	Mutual of Omaha ¹⁰ -----	. 577 -----	7
	New Hampshire-Vermont Blue Shield -----	. 843 -----	41
	Nationwide ¹¹ -----	. 947 -----	46

¹ Rankings based on 51 carriers, counting Travelers' service of Railroad Retirement annuitants as a separate entity.

² Data for separate components of multi-State carriers not available; man-hours per paid bill processed by such carriers are shown at end of table.

³ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁴ Aetna has separate service areas in Alaska, Arizona, Hawaii, Nevada, Oklahoma, and Oregon.

⁵ District of Columbia Blue Shield has separate service areas in the District of Columbia, Maryland, and Virginia.

⁶ Equitable has separate service areas in Idaho, New Mexico, Tennessee, and Wyoming.

⁷ Blue Shield of Kansas City, Mo., has separate service areas in Kansas and Missouri.

⁸ Metropolitan has separate service areas in Kentucky and New York.

⁹ Travelers has separate service areas in Minnesota, Mississippi, and Virginia.

¹⁰ Mutual of Omaha has separate service areas in Nebraska and the Virgin Islands.

¹¹ Nationwide has separate service areas in Ohio and West Virginia.

5. (p) *Please rank each of the carriers on the basis of * * * ratio of assigned claims to total claims.*

The enclosed table lists, for each carrier service area, the proportion of all Forms SSA-1490, Request for Payment, on which physicians agreed to accept assignment of the claim for reimbursement under Medicare. These claims exclude those involving services of hospital-based physicians, nearly all of which are paid on the basis of assignments. They include claims for which no payment was subsequently approved (for reasons such as failure to meet the deductible requirement, etc.)

Proportion of claims received by carriers in which physicians agreed to accept payment on the basis of assignments, April-June 1968

State	Carrier	Assign- ments (percent)	Rank ¹
Alabama	Blue Shield	56.2	43
Alaska	Aetna	67.9	21
Arizona	do	49.3	56
Arkansas	Blue Shield	68.7	18
California	do	81.5	5
	Occidental	52.8	52
Colorado	Blue Shield	82.0	4
Connecticut	Conn. General	54.8	47
Delaware	Blue Shield	66.7	26
District of Columbia	do	36.4	64
Florida	do	42.6	60
Georgia	John Hancock	53.6	49
Hawaii	Aetna	44.3	58
Idaho	Equitable	65.0	28
Illinois	Blue Shield	40.0	61
	Continental Casualty	52.9	51
Indiana	Blue Shield	45.3	57
Iowa	do	60.9	34
Kansas	Blue Shield of Topeka	68.0	20
	Blue Shield of Kansas City, Mo.	71.7	10
Kentucky	Metropolitan	82.3	3
Louisiana	Pan American	76.4	7
Maine	Union Mutual	70.1	14
Maryland	Blue Shield of Maryland	67.5	23
	District of Columbia Blue Shield	67.5	23
Massachusetts	Blue Shield	83.0	2
Michigan	do	57.9	39
Minnesota	do	60.8	35
	Travelers	49.4	55
Mississippi	do	61.8	32
Missouri	Blue Shield	56.0	44
	General American	69.1	17
Montana	Blue Shield	61.9	31
Nebraska	Mutual of Omaha	52.3	54
Nevada	Aetna	71.0	12
New Hampshire	Blue Shield	69.4	16
New Jersey	Prudential	53.3	50
New Mexico	Equitable	63.0	29
New York	Blue Shield of Buffalo	70.7	13
	Blue Shield of New York City	38.3	63
	Blue Shield of Rochester	66.9	25
	Metropolitan	74.3	8
	Group Health	24.8	67
North Carolina	Pilot Life	52.8	52
North Dakota	Blue Shield	71.6	11
Ohio	Nationwide	39.1	62
	Blue Shield of Cleveland	23.4	68
Oklahoma	Aetna	60.1	36
	Department of Welfare ²	99.6	1
Oregon	Aetna	57.2	41
Pennsylvania	Blue Shield	56.0	44
Rhode Island	do	77.8	6
South Carolina	do	56.6	42
South Dakota	do	58.6	38
Tennessee	Equitable	57.5	40
Texas	Blue Shield	66.1	27

See footnotes at end of table, p. 323.

Proportion of claims received by carriers in which physicians agreed to accept payment on the basis of assignments, April-June 1968—
Continued

State	Carrier	Assign- ments (percent)	Rank ¹
Utah.....	Blue Shield.....	53.9	48
Vermont.....	do.....	73.8	9
Virginia.....	Travelers.....	43.6	59
	District of Columbia Blue Shield.....	28.3	66
Washington ³	Blue Shield.....	59.1	37
West Virginia.....	Nationwide.....	67.9	21
Wisconsin.....	Blue Shield of Madison.....	70.0	15
	Blue Shield of Milwaukee.....	61.1	33
Wyoming.....	Equitable.....	62.1	30
Puerto Rico.....	Blue Shield.....	68.5	19
Virgin Islands.....	Mutual of Omaha.....	35.2	65
Railroad.....	Travelers.....	55.5	46
	SSA.....	(4)	(4)

¹ Based on 68 carrier service areas.

² Assignment of claims is required because of coordination with title XIX.

³ The claims operation of this carrier is decentralized on a county basis. The figure shown, however, is a composite of all experience within the State.

⁴ Not applicable.





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